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In the Supreme Court of the United States

OCTOBER TERM, 1993

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES, PETITIONER

v.

MOTHER FRANCES HOSPITAL OF TYLER, TEXAS

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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QUESTIONS PRESENTED

1. Whether general Medicare record-keeping and reporting regulations require that provider costs be reimbursed according to "generally accepted accounting principles," despite contrary administrative rules issued by the Secretary of Health and Human Services to govern reimbursement of particular types of costs.

2. Whether, if the regulations do not impose such a requirement, the provision of the Medicare Provider Reimbursement Manual on which the Secretary relied in denying reimbursement in this case is invalid as a legislative rule issued without compliance with the notice-and-comment provisions of the Administrative Procedure Act.

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v.

MOTHER FRANCES HOSPITAL OF TYLER, TEXAS

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

The Solicitor General, on behalf of the Secretary of Health and Human Services, petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-10a) is reported at 15 F.3d 423. The opinion of the district court (App., *infra*, 13a-27a) is reported at 818 F. Supp. 990. The Report and Recommendation of the United States Magistrate Judge (App., *infra*, 28a-43a), the decision of the Administrator of the Health Care Financing Administration (App., *infra*, 44a-60a) and the decision of the Provider Reimbursement Review Board (App., *infra*, 61a-87a) are unreported.

JURISDICTION

The judgment of the court of appeals was entered on March 3, 1994. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTES AND REGULATIONS INVOLVED

1. Section 1861(v)(1)(A) of the Social Security Act, 42 U.S.C. 1395x(v)(1)(A), provides in pertinent part as follows:

> The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services * * *. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific

items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. * * *

2. The regulations of the Secretary of Health and Human Services implementing 42 U.S.C. 1395x(v)(1)(A), 42 C.F.R. Pt. 413, provide in pertinent part as follows:

§ 413.9 Costs related to patient care.

(a) *Principle.* All payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenues and cost.

* * * * *

§ 413.20 Financial data and reports.

(a) *General.* The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basi[c] accounts, as usually

maintained, to arrive at equitable and proper payment for services to beneficiaries.

* * * * *

§ 413.24 Adequate cost data and cost finding.

(a) *Principle.* Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.

* * * * *

(b) *Definitions*–

* * * * *

(2) *Accrual basis of accounting.* Under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

3. Section 233 of the Secretary's Provider Reimbursement Manual is reprinted at App., *infra,* 88a-91a.

STATEMENT

1. Medicare is a national program of health insurance for the aged and disabled. Part A of Medicare provides for the payment of inpatient hospital and related post-institutional care for the eligible individuals who are the program's "beneficiaries." 42 U.S.C. 1395c, 1395d, 1395i (1988 & Supp. IV 1992). Services are furnished under Part A by "providers of services" (*e.g.*, hospitals), which participate by entering into a "provider agreement" with the

Secretary. 42 U.S.C. 1395x(u), 1395cc (1988 & Supp. IV 1992). The Secretary reimburses Medicare providers on an annual basis through "fiscal intermediar[ies]." 42 U.S.C. 1395g, 1395h.

Respondent Mother Frances Hospital of Tyler, Texas, provides medical services to eligible Medicare beneficiaries, for which it is reimbursed under the Medicare program. For the 1987 cost year at issue in this case, Medicare providers like respondent were generally reimbursed for capital-related costs on a "reasonable cost" basis.[1] The Medicare Act defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services" to beneficiaries. 42 U.S.C. 1395x(v)(1)(A). The Act authorizes the Secretary of Health and Human Services to promulgate regulations "establishing the method or methods to be used" for determining such costs. *Ibid.* The Secretary's regulations setting forth general principles of reasonable cost reimbursement are codified at 42 C.F.R. Pt. 413.[2]

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[1] Since October 1, 1983, hospitals have been reimbursed for general inpatient operating costs under a system of predetermined rates known as the "prospective payment system" or "PPS." See 42 U.S.C. 1395ww(d) (1988 & Supp. IV 1992); 42 C.F.R. Pt. 412. Reimbursement for capital-related costs (like those involved in this case) continued to be made on a "reasonable cost" basis until the beginning of a transition to a "capital PPS" on October 1, 1991. The transition is scheduled to be completed by October 1, 2001. See 42 C.F.R. 412.304.

[2] The Medicare "reasonable cost" regulations were originally codified at 20 C.F.R. Pt. 405 (1967). They have been twice redesignated, first at 42 C.F.R. Pt. 405 (1977), see 42 Fed. Reg. 52,826 (1977), and most recently at 42 C.F.R. Pt. 413, see 51 Fed. Reg. 34,790 (1986). Neither redesignation affected the substance of the regulations at issue in this case. In this petition, we refer to the regulations as currently codified, giving parallel citations only where they seem useful.

2. In 1983, the City of Tyler, Texas issued bonds on respondent's behalf in the amount of $52,335,000 to raise money for various capital improvements to respondent's facilities. Admin. Rec. 1114, 1116.[3] The bonds were secured by mortgages on hospital property, bore interest at rates ranging from 8.6% to 9.5%, and were scheduled to reach maturity in 1998. See *ibid.* Outstanding bonds from the 1983 series could also, at respondent's option, be repaid (called) in 1993 in exchange for the payment of a "call premium" (prepayment penalty) in addition to the basic principal amount. See Admin. Rec. 1030.

The interest payments on the 1983 bonds, as well as the costs associated with their issuance (such as underwriter's discounts and legal and accounting fees), were allowable capital-related costs for purposes of Medicare reimbursement. See, *e.g.*, 42 C.F.R. 413.130(a)(7) and (g); 42 C.F.R. 413.153. Interest costs on the bonds were incurred and reimbursed annually by Medicare each year that the bonds remained outstanding. Respondent's bond issuance costs, by contrast, were fully incurred in 1983 when the bonds were issued but were not reimbursable in full in the year incurred. Instead, both for financial accounting and Medicare reimbursement purposes, the bond issuance costs were amortized as part of the provider's costs over the life of the bonds.

3. In 1987, respondent refinanced the 1983 bonds in an "advance refunding" or "defeasance" transaction. See

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[3] In fact, the 1983 bonds were issued to refinance an earlier 1981 bond issuance for capital improvements in the amount of $42,500,000. Admin. Rec. 1030, 1241. The 1981 and 1983 bonds, as well as the 1987 bonds discussed below, were issued by the Tyler Health Facilities Development Corporation, a corporation established by the City of Tyler, Texas, under the Texas Health Facilities Development Act. Admin. Rec. 1017, 1018A, 1114.

Admin. Rec. 214, 1017.[4] In that transaction, the bulk of the proceeds of the new bonds issued by respondent were transferred into an irrevocable escrow account established under the control of a trustee for the purpose of paying interest on the old bonds while they remained outstanding and retiring them at the earliest possible date. See App., *infra*, 2a. Under the terms of the old bonds, the establishment and funding of the escrow account released respondent from any further obligation to the holders of those bonds. Respondent estimated that refinancing with the new bonds—at interest rates varying from 4.1% to 7.0% (depending on their maturity)—would save $2,714,975 over the remaining original term of the prior bond issue. *Id.* at 3a n.3; Admin. Rec. 146. Because the amount that respondent was required to pay into the escrow account to defease its obligations under the 1983 bonds exceeded the net amount at which those bonds were carried on respondent's books, respondent realized, at the time of the transaction, an accounting loss equal to that difference.[5] App., *infra*, 2a.

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[4] The parties stipulated that respondent's "advance refunding" transaction was similar to transactions entered into by three other Medicare providers (including Guernsey Memorial Hospital, the respondent in *Shalala* v. *Guernsey Memorial Hospital*, cert. granted, 114 S. Ct. 1395 (1994) (No. 93-1251)). The parties also stipulated to the admission in this case of the expert testimony before the PRRB concerning those other transactions. See Admin. Rec. 433-705. Consequently, there is little testimony in the record of this case relating specifically to respondent's "advance refunding" transaction.

[5] For these purposes the net carrying amount of the refunded debt consisted of the combined outstanding principal amounts of the 1983 bonds, increased by accrued but unpaid interest, and offset by all of the original bond issuance costs that remained unamortized at the time of the refunding transaction. See *Early Extinguishment of Debt*, Accounting Principles Board Opinion No. 26, ¶ 3(b) (1972) (APB Opinion). The difference between that amount and the amount that re-

4. a. For financial reporting purposes, respondent reflected the full amount of the refunding loss of $7,376,102 on its financial statement for fiscal year 1987, in accordance with "generally accepted accounting principles" (GAAP) as set out in *Early Extinguishment of Debt*, Accounting Principles Board Opinion No. 26, ¶ 3(b) (1972) (APB Opinion 26).[6] See Admin. Rec. 1235. Respondent also sought to claim a "loss" of $11,671,393 as reimbursable costs under Medicare for patient care in that year.[7]

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spondent paid into escrow – that is, the accounting loss recognized on the transaction – reflects not only the unamortized issuance costs, but also a call premium on the 1983 bonds (payable to holders when the bonds were called by the escrow trustee in 1993, but funded in advance by respondent's payment into the escrow account) and the difference between the interest rates payable on the refunded bonds and rates prevailing at the time of the refunding transaction (which affected the amount necessary to fund the escrow account).

[6] GAAP consists of principles established by certain "standards setting organizations" and professional societies. Two of the "standards setting organizations" are the Financial Accounting Standards Board, and the Government Accounting Standards Board; the professional societies include the American institute of Certified Public Accountants. See D.R. Carmichael, S. Lilien & M. Mellman, *Accountants' Handbook*, §§ 2.4(a), 2.5, 2.9 (7th ed. 1991). In the absence of an applicable formal standard from one of those organizations, what is "generally accepted" depends on "the consensus of the accounting profession" as manifested in treatises and other publications. See *ibid.*; Pet. App. 3a n.4.

[7] In the court of appeals, respondent explained that the difference between the $7 million and $11 million loss calculations is that the former is "net of Medicare reimbursement impact." Mother Frances C.A. Br. 14. Before the district court, respondent submitted a worksheet (which it claimed was prepared by the fiscal intermediary) showing a "loss" of $11,671,393. Respondent's complaint in this case, however, asserted that its "loss," applying GAAP, was $10,847,102. The Secretary denied that any of those various estimates accurately states the amount of respondent's "loss" on its "advance refunding" transaction.

The "fiscal intermediary" responsible for review of respondent's cost report allowed only $824,727 in reimbursement for 1987 and required the additional amounts claimed by respondent to be amortized over the remaining life of the old bonds. Admin. Rec. 1136-1137. The intermediary's determination relied on a guideline contained in the Secretary's Provider Reimbursement Manual (PRM), an extensive set of detailed policies and guidelines issued to assist providers and intermediaries in applying the principles of reimbursement set forth in the Medicare regulations. See 1, 2 Medicare & Medicaid Guide (CCH) ¶¶ 4600-8113 (1993).

Section 233 of the PRM, issued in 1983 and reprinted at App., *infra,* 88a-91a, applies to "advance refunding" transactions like that undertaken by respondent in 1987. Section 233 identifies the individual expense elements of an "advance refunding" transaction and specifies when such expenses are allowable for Medicare reimbursement purposes. It provides, for example, that while incidental expenses (such as legal fees) relating to the refunding transaction are allowable as soon as paid or accrued, "call premiums" are not allowable until the period in which they are in fact paid to holders of the refunded debt, and unamortized issuance costs of the refunded debt must be amortized over the period from the issuance of the refunding debt to the date that the refunded debt is actually retired. PRM § 233.3(B)(1), (B)(3) and (C). The overall approach of Section 233 is "to implicitly recognize any gain or loss incurred as the result of an advance refunding over [the period that the principal of the old debt remains unpaid], rather than immediately." PRM § 233.3.

b. Respondent appealed to the Provider Reimbursement Review Board (PRRB) (see 42 U.S.C. 1395*oo*(a); 42 C.F.R. 405.1835-405.1873), which reversed the fiscal intermediary's determination. App., *infra,* 61a-87a. With-

out directly addressing the validity of PRM § 233, the PRRB held that Sections 413.20 and 413.24 of the Secretary's Medicare regulations (formerly Sections 405.406 and 405.453, respectively) required that costs allowed for Medicare reimbursement purposes must be determined according to GAAP. App., *infra*, 76a.

c. The Administrator of the Health Care Financing Administration reversed the PRRB's decision. App., *infra*, 44a-60a. While recognizing that "GAAP can be useful in determining costs related to patient care," the Administrator rejected the PRRB's position that the Secretary's regulations required that GAAP be followed in all cases. App., *infra*, 49a-50a. Under PRM § 233, "Medicare [had] a specific policy in effect governing the treatment of refunding transactions" during the year in question. App., *infra*, 49a. That policy recognized that the refunding loss was related to patient care provided in all of the years during which the original bonds remained outstanding and not merely in the year of the refunding transaction. *Id.* at 49a, 56a-58a. The Administrator therefore ruled that, for Medicare purposes, the refunding loss should be treated in accordance with Section 233 of the PRM, rather than in accordance with GAAP. *Id.* at 60a.

5. a. Respondent sought judicial review of the Administrator's determination. See 42 U.S.C. 1395*oo* (f)(1); 42 C.F.R. 405.1877. The district court referred the matter to a Magistrate for a Report and Recommendation. See 28 U.S.C. 636(b). The Magistrate recommended that the Administrator's determination be reversed. App., *infra*, 28a-43a. The Magistrate concluded that the Secretary's regulations—in particular, 42 C.F.R. 413.20 and 42 C.F.R. 413.24—"call for the use of GAAP" in determining reimbursement and that the Secretary's contrary interpretation of those regulations was "unreasonable." App., *infra*, 38a. The Magistrate further concluded that Section

233 is invalid as a substantive rule adopted without compliance with the public notice and comment procedures of the Administrative Procedure Act (APA) 5 U.S.C. 551 *et seq.* App., *infra,* 39a. The Magistrate concluded that respondent's "loss" on the refinancing was $11,671,393, and that the reimbursable portion of that "loss" under Medicare was $4,563,362. *Id.* at 30a, 41a-43a.

b. The district court rejected the Magistrate's Report and Recommendation and upheld the Administrator's determination. App., *infra,* 13a-27a. The court held that the plain language of the regulations did not support the conclusion "that GAAP applies to cost reimbursement principles" (*id.* at 18a). The court rejected the Magistrate's conclusion that PRM § 233 was an invalid, legislative rule under the APA (App., *infra,* 22a) and further held that the Magistrate erred in determining the amount of respondent's "loss" since that issue was not properly before the court (*id.* at 26a).

c. The court of appeals reversed. App., *infra,* 1a-10a. The court agreed with the Sixth Circuit in *Guernsey Memorial Hospital* v. *Secretary of HHS,* 996 F.2d 830 (1993), cert. granted, 114 S. Ct. 1395 (1994) (No. 93-1251), that 42 C.F.R. 413.20 and 42 C.F.R. 413.24 "provide for use of GAAP in determining the timing of Medicare reimbursement in advance refunding transactions and that section 233 [of the Provider Reimbursement Manual], which provides to the contrary, is an invalid attempt to promulgate a substantive rule without complying with the rulemaking formalities" of the APA. App., *infra,* 8a. In so ruling, the panel distinguished its earlier decision in *Sun Towers, Inc.* v. *Heckler,* 725 F.2d 315 (5th Cir.), cert. denied, 469 U.S. 823 (1984), where the court had held that 42 C.F.R. 413.20 "only provides that accepted accounting [practices] be used in uniform record-keeping, not in determining costs allowable under the Medicare Act" (725

F.2d at 328-329, quoting *American Medical Int'l, Inc.* v. *Secretary of HHS*, 466 F. Supp. 605, 623 (D.D.C. 1979), aff'd, 677 F.2d 118 (D.C. Cir. 1981)). The panel stated that *Sun Towers* was concerned with "*whether* a particular cost was allowable at all," whereas the issue in the instant case, "as it was in the *Guernsey* case, * * * is *when* a cost that was clearly allowable should have been reimbursed." App., *infra*, 10a. The court of appeals therefore remanded the case to the Secretary for a determination of the exact amount of respondent's advance refunding "loss" and for reimbursement. *Ibid.*

REASONS FOR GRANTING THE PETITION

This case presents the same questions that are presented in *Shalala* v. *Guernsey Memorial Hospital*, cert. granted, 114 S. Ct. 1395 (1994) (No. 93-1251). The petition should therefore be held and disposed of as appropriate in light of the Court's disposition of *Guernsey Memorial Hospital*.[8]

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[8] Respondent has been provided with a copy of the petition and the merits brief filed by the Secretary in the *Guernsey Memorial Hospital* case.

CONCLUSION

The petition for a writ of certiorari should be held and disposed of as appropriate in light of the Court's disposition of *Shalala* v. *Guernsey Memorial Hospital*, cert. granted, 114 S. Ct. 1395 (1994) (No. 93-1251).

Respectfully submitted.

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MAY 1994

APPENDIX A

UNITED STATES COURT OF APPEALS
FIFTH CIRCUIT

No. 93-4388

MOTHER FRANCES HOSPITAL OF TYLER, TEXAS,
PLAINTIFF-APPELLANT,

v.

DONNA E. SHALALA, IN HER OFFICIAL CAPACITY AS SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND WILLIAM TOBY, JR., IN HIS OFFICIAL CAPACITY AS ACTING ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION, DEFENDANTS-APPELLEES.

March 3, 1994

Appeal from the United States District Court
for the Eastern District of Texas

Before JOHNSON, GARWOOD, and JOLLY, Circuit Judges.

JOHNSON, Circuit Judge:

The dispute in this case concerns the timing of Medicare reimbursement payments for costs incurred by provider hospitals under the Medicare Program. The particular costs at issue herein stem from an "advance refunding"

transaction conducted by Mother Frances Hospital of Tyler, Texas (the "Hospital") in 1987. In that transaction, the Hospital incurred "defeasance" costs when it refunded an old series of bonds ahead of schedule in order to obtain new financing. All parties agree that these costs are reimbursable. The only issue that is contested is when and how this reimbursement is to be made. The Hospital maintains that such a loss is reimbursable immediately in a lump sum. By contrast, the Secretary of Health and Human Services (the "Secretary") contends that reimbursement should be amortized over the life of the old bonds. The district court ruled in favor of the Secretary. We REVERSE.

I.

FACTS AND PROCEDURAL HISTORY

In 1987, the Hospital borrowed money by issuing a new series of bonds. Most of the proceeds of this 1987 bond issue were used in an "advance refunding" transaction to refinance an earlier, 1983 bond issue. In this transaction, the Hospital placed the funds from the new bond issue into an irrevocable trust account under the direction of an independent trustee. The trustee invested this money in U.S. Treasury obligations at an interest rate sufficient to pay the principal and interest of the old bonds as they came due. By means of this transaction, the Hospital was able to transfer its legal liability for the 1983 bonds to the trustee. Thus, the Hospital's liability for the bonds was "defeased."

As a result of this transaction, the Hospital incurred a loss.[1] This loss occurred because in order to create a sufficient fund in the trust to service the old bonds, the Hospital had to borrow a greater principal amount in the new bond issue.[2] Thus, after the 1987 transaction, the Hospital had

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[1] This loss amounted to in excess of $11 million of which Medicare will reimburse approximately $4 million.

[2] Also added to this loss were certain up-front transactional costs the Hospital incurred in this transaction.

a greater debt.[3]

Acting in accordance with Generally Accepted Accounting Principles (GAAP)[4], as is required by 42 C.F.R. § 413.20, the Hospital sought reimbursement for this entire loss in 1987. This request was denied, though, by the "fiscal intermediary"[5] to which such requests are initially routed. Instead, the intermediary allowed only a portion of this loss in 1987 and sought to space out this remaining reimbursement by amortizing it over the life of the old bonds. The Hospital appealed this decision to the Provider Reimbursement Review Board, a body established by the

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[3] Even though this transaction would result in a greater debt for the Hospital, it still made economic sense because, owing to lower interest rates, the new financing could be obtained on more favorable terms than the old financing. Thus, in reality, the Hospital would end up with a net economic gain because of reduced interest expense.

[4] GAAP consists of the three official publications of the American Institute of Certified Public Accountants (AICPA). These publications are the Accounting Principles Board Opinions, the Financial Accounting Standards Board statements, and the Accounting Research Bulletins. *See HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179, 1181 n 3 (9th Cir. 1989). In 1972, the Accounting Principles Board issued APB Opinion 26 which is entitled "Early Extinguishment of Debt." This opinion states that "[a] difference between the reacquisition price and the net carrying amount of the extinguished debt should be recognized currently in income of the period of extinguishment as losses or gains and identified as a separate item. . . . Gains and losses should not be amortized to future periods." Opinion 26, ¶ 20.

[5] The Medicare program provides for the payment of inpatient hospital and related post-institutional care for eligible individuals. These medical services are rendered by provider hospitals which participate in the Medicare program by entering into a "provider agreement" with the Secretary. 42 U.S.C. §§ 1395x(u), 1395cc. The Secretary then reimburses those provider hospitals through a "fiscal intermediary." 42 U.S.C. §§ 1395g, 1395h. In this case, the fiscal intermediary was Blue Shield of Texas, Inc.

Secretary pursuant to 42 U.S.C. § 1395*oo* to hear these appeals. Finding that the regulations implementing the Medicare program provided for the use of GAAP in the absence of specific regulations to the contrary, the Board reversed the decision of the intermediary and issued a decision calling for full reimbursement in 1987.

The Board's decision was, in turn, reviewed by the Administrator of the Health Care Finance Administration. In making his decision, the Administrator relied on a policy announced in section 233 of the agency's Provider Reimbursement Manual (PRM) calling for amortization of advance refunding costs. Accordingly, the Administrator reversed the decision of the Board. Under 42 C.F.R. § 405.1875, this decision represented the final decision of the Secretary.

From this decision, the Hospital appealed to the district court where arguments were heard before a magistrate judge. The magistrate judge issued a Report and Recommendation in favor of the Hospital finding that section 233 was no more than a manual provision without the force and effect of law and thus was ineffective to change the meaning of the governing regulations, 42 C.F.R. § 413.20(a) and 413.24(a) and (b)(2), which call for the use of GAAP. This recommendation was rejected by the district judge, however, who found that section 233 was merely interpretive of the regulations and was therefore valid. Hence, the district court granted summary judgment for the Secretary, 818 F.Supp. 990. The Hospital timely appeals from this decision.

II.

DISCUSSION

Under the Medicare statute, the Secretary must reimburse provider hospitals for the reasonable costs of serv-

ices rendered to eligible Medicare beneficiaries. The calculation of these reasonable costs "shall be determined in accordance with regulations establishing the method or methods to be used. . . ." 42 U.S.C. § 1395x(v). Moreover, "[i]n prescribing the regulations, the Secretary shall consider, among other things, the principles generally applied by national organizations. . . ." *Id.* These "national organizations" utilize GAAP.

This statute only states that the Secretary must "consider" GAAP in making regulations. It does not say that she must pass regulations adopting GAAP. However, under 42 C.F.R. § 413 *et. seq.*, entitled "Principles of Reasonable Cost Reimbursement," she appears to have done so. Under section 413.20(a), the regulations state that

> [t]he principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields *are followed* (emphasis added).

Moreover, section 413.24(a) states that "[t]he cost data *must* be based on an approved method of cost finding and on the accrual basis of accounting." Lastly, section 413.24(b)(2) instructs that

> [u]nder the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected, *and expenses are reported in the period in which they are incurred, regardless of when they are paid* (emphasis added).

In light of GAAP, the manifest conclusion from reading these regulations is that the Hospital was entitled to full reimbursement for this advance refunding loss in 1987.

Nevertheless, the Secretary seeks to avoid this result. She argues that the regulations merely provide for GAAP

with respect to a hospital's *reporting* of its costs and do not compel a result with respect to the timing of cost *reimbursement*. Instead, she maintains that the timing of cost reimbursement in advance refunding transactions should be governed by PRM § 233. This provision speaks directly to advance refunding transactions and, contrary to GAAP, clearly provides for amortization of the loss.[6]

This argument by the Secretary has not fared well in the federal courts. Aside from the decision by the district court herein, every district court to have addressed the issue of the timing of reimbursement for an advance refunding loss has held, consistent with GAAP and contrary to the Secretary's argument, that this loss is immediately reimbursable.[7] Further, this issue was thoroughly discussed and the Secretary's arguments were rejected by the Sixth Circuit in *Guernsey Memorial Hosp. v. Secretary of Health and Human Services*[8], 996 F.2d 830 (6th Cir.1993).

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[6] Specifically, this section instructs that:

> When a provider defeases or repurchases debt incurred for necessary patient care through an advance refunding . . . [u]namortized discounts or premiums (reduction of debt cancellation costs) and debt issue costs of the refunded debt must be amortized over the period from the issue date of the refunding debt to the date the holders of the refunded debt will receive the principal payment . . ."

[7] *Graham Hospital Ass'n v. Sullivan,* 832 F.Supp. 1235, 145 (N.D.Ill.1993); *Baptist Hospital East v. Sullivan,* 767 F.Supp. 139 (W.D.Ky.1991); *Mercy Hospital v. Sullivan,* Civil No. 90-0024 P, 1991 WL 104090 (D.Me.April 25, 1992); *Ravenswood Hospital Medical Ctr. v. Schweiker, 622 F.Supp. 338 (N.D.Ill.1985); Methodist-Evangelical Hospital, Inc. v. Shalala,* Civil No. 92-2887-LFO.1993 WL 548830 (D.D.C. Dec. 22, 1993); *Grant Medical Center v. Shalala,* Civil No. 93-0470-LFO, 1993 WL 548830 (D.D.C. Dec. 22, 1993).

[8] The district court in the *Guernsey* case had ruled in favor of the Secretary, but that decision was reversed by the Sixth Circuit.

In *Guernsey*, a case on all fours with the case *sub judice*, the Sixth Circuit determined that the language and structure of the Medicare regulations unambiguously provide that reimbursement will be made on the basis indicated by GAAP. *Id.* at 835. Specifically, the court found that

> [w]ere it not for § 233 of the Provider Reimbursement Manual, any fair minded person reading the regulations in the light of generally accepted accounting principles would have to conclude that [the hospital] was entitled to reimbursement for its advance refunding costs in the year in which, under GAAP, the costs were deemed to have been incurred.

Id. at 834.

As to section 233, the *Guernsey* court concluded that it was invalid. *Id.* at 835. This is because issuance of the Provider Reimbursement Manual was not preceded by the formal rulemaking requirements of 5 U.S.C. § 553[9] and thus it does not carry the force and effect of law or regulation. *National Medical Enterprises v. Bowen*, 851 F.2d 291, 293 (9th Cir.1988). Lacking these formal requisites, section 233 could only be valid if it were an "interpretive" rule as opposed to a "substantive" rule.[10] *See* 5 U.S.C. § 553(b)(A).

Accordingly, the Secretary argued in *Guernsey*, as she argues herein, that section 233 merely interprets the regulations. The *Guernsey* court, however, disagreed. It

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[9] These requirements include advance notice of the terms or substance of a proosed rule under § 553(b) and an opportunity for interested persons to comment through the submission of written data, views or argument under § 553(c).

[10] Interpretive rules clarify or explain existing law or regulations; substantive rules grant rights, impose obligations or produce other significant effects on private interests. *American Hospital Association v. Bowen*, 834 F.2d 1037, 1045 (D.C.Cir.1987).

found that as opposed to merely interpreting existing regulations, section 233 impermissibly changed the meaning of the properly promulgated regulations. *Id.* at 835; *See also Graham,* 832 F.Supp. at 1243. Hence, the *Guernsey* court found that section 233 worked a substantive change in the regulations and was thus an invalid attempt to make a substantive rule without the formalities of the Administrative Procedures Act.[11] *Guernsey,* 996 F.2d at 832.

We agree with the reasoning of *Guernsey* and adopt its holding that the Medicare regulations provide for the use of GAAP in determining the timing of Medicare reimbursement in advance refunding transactions and that section 233, which provides to the contrary, is an invalid attempt to promulgate a substantive rule without complying with the rulemaking formalities. Moreover, we see nothing contrary to this holding in our decision in *Sun Towers, Inc. v. Heckler, 725 F.2d 315 (5th Cir.), cert. denied,* 469 U.S. 823, 105 S.Ct. 100, 83 L.Ed.2d 45 (1984).

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[11] Also, the *Guernsey* court rejected the Secretary's attempted distinction between the Hospital's *reporting* of its costs and the *reimbursement* for those costs. The Secretary argued that the regulations mandated the use of GAAP only for the Hospital's internal cost *reporting* and that § 233 was sufficient to establish a different accounting system for cost *reimbursement.* In rejecting this argument, the court noted that the purpose of cost reporting was to enable the Hospital's costs to be known so that reimbursement could be calculated. For that reason, the court felt that there should be a nexus between the fundamental principles of cost reporting and cost reimbursement. Accordingly, the *Guernsey* Court found that § 233 was ineffective because "[t]he 'nexus' that exists in the regulations between cost reporting and cost reimbursement is too strong . . . to be broken by a rule not adopted in accordance with the rule making requirements of the Administrative Procedures Act." *Id.* at 836. We agree with this statement.

In *Sun Towers,* this Court was called on to decide whether certain costs were allowable under the Medicare program. Among these costs were "stock maintenance costs."[12] *Id.* at 326. The Secretary disallowed reimbursement for these costs finding that they were only tangentially related to the care of Medicare beneficiaries.[13] The district court, however, reversed the Secretary's determination.

Among the arguments the district court presented to support its decision in *Sun Towers* was an argument based on GAAP. *Id.* at 328. Under GAAP, stock maintenance costs are recognized as general and administrative expenses. Thus, the district court argued that these costs were allowable because 42 C.F.R. § 405.406[14] required GAAP to be applied in determining reasonable costs. *Id.*

We rejected this argument holding that GAAP was not necessarily to be used in determining if a particular cost was allowable. *Id.* at 328-29. In particular, we found that section 405.406 was not designed to determine the *"costs allowable* under the Medicare Act. The regulation is directed at the type of financial data and reports required of providers; it is not a regulation affecting the substantive provisions of the program as to *what constitutes reimbursable costs." Id.* at 329 (quoting *American Medical International, Inc. v. Secretary of Health, Education and Welfare,* 466 F. Supp. 605, 623 (D.D.C. 1979), *aff'd*

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[12] These costs consisted of 1) stock transfer and registration fees; 2) reports to stockholders; 3) stockholders' meetings; 4) legal and accounting fees incurred through the SEC filings and stockholders' meetings; and 5) public relations aimed at institutional investors.

[13] Medicare does not reimburse all expenses, but only those that are reasonably related to patient care. *Id.* at 328 n. 25; 42 U.S.C. § 1395x(v)(1)(A).

[14] This section was the precursor to § 413.20.

677 F.2d 118 (D.C.Cir.1981) (emphasis added). Hence, we reversed the decision of the district court and held that the Secretary's determination was neither arbitrary nor capricious. *Sun. Towers,* 725 F.2d at 330.

In *Sun Towers,* the issue was *whether* a particular cost was allowable at all. In the case at bar, as it was in the *Guernsey* case, the issue is *when* a cost that was clearly allowable should have been reimbursed. These are different questions and we do not believe that *Sun Towers* speaks to the issue of *when* reimbursement is to be made.

Accordingly, we adhere to our decision in *Sun Towers* as to *whether* a particular cost is allowable. However, we follow *Guernsey* as to *when* advance refunding costs are to be reimbursed.

III.

CONCLUSION

For the reasons stated above, we hold that, under the applicable Medicare regulations, the Hospital was entitled to reimbursement for the full amount of its advance refunding loss in 1987 plus interest. Therefore, we REVERSE the decision of the district court and REMAND this case for a determination of the exact amount of the advance refunding loss and the amount reimburseable under Medicare plus interest from 1987.[15]

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[15] The Hospital argues that we should hold that the fiscal intermediary's figure of $11,671,393 is correct as to the amount of the advance refunding loss. However, this factual issue was not decided by the PRRB or the Secretary, it was not before the district court, and we do not address it. *See Presbyterian Hospital of Dallas v. Harris,* 638 F.2d 1381, 1389 (5th Cir.). *cert. denied.* 454 U.S. 940, 102 S.Ct. 476, 70 L.Ed.2d 248 (1981).

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

6:92 CV 337

MOTHER FRANCES HOSPITAL OF TYLER, TEXAS, PLAINTIFF,

v.

DONNA SHALALA, PH.D.,[1] SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., DEFENDANTS.

[FILED MAR 26, 1993]

AMENDED FINAL JUDGMENT

In accordance with the memorandum opinion filed simultaneously herewith in the above-entitled and numbered civil action, it is

ORDERED, ADJUDGED, AND DECREED that the January 8, 1993, report and recommendation of the Magistrate Judge, granting the motion for summary judgment filed by plaintiff, Mother Frances Hospital of Tyler,

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[1] The initial defendant in this civil action was ex-Secretary of the Department of Health and Human Services, Louis W. Sullivan. The current Secretary is Donna Shalala. Under the Federal Rules of Civil Procedure, Rule 25(d), when a public official who is party to an action ceases to hold office, "the action does not abate and the officer's successor is automatically substituted as a party."

Texas, denying the motion for summary judgment filed by the defendants, the Secretary of Health and Human Services, *et al.*, and reversing the final decision of the defendant Secretary, shall be, and is hereby, REJECTED. Further, it is

ORDERED, ADJUDGED, AND DECREED that the defendant Secretary of Health and Human Services' decision to amortize the Medicare reimbursement for the loss on bond defeasance incurred by the plaintiff, Mother Frances Hospital, is approved and confirmed; and it shall be, and is hereby, REINSTATED. Further it is

ORDERED, ADJUDGED, AND DECREED that the report and recommendation of the Magistrate Judge, finding $11,671,393.00 to be the total loss due to the refinancing transaction, and $4,563,362.00 to be the total reimbursement effect on Medicare, shall be, and it is hereby, REJECTED. Further, it is

ORDERED, ADJUDGED, AND DECREED that the determination of the total loss due to the refinancing transaction and the total reimbursement effect on Medicare, shall be, and it is hereby, REMANDED to the Department of Health and Human Services and the Health Care Financing Administration, for an initial determination of this issue.

SIGNED this 26th day of March, 1993.

/s/ Wm. Wayne Justice

WILLIAM WAYNE JUSTICE
United States District Judge

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

6:92 CV 337

MOTHER FRANCES HOSPITAL OF TYLER, TEXAS, PLAINTIFF

v.

DONNA SHALALA, PH.D,[1] SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., DEFENDANTS

[FILED MAR 23, 1993]

MEMORANDUM OPINION

I. Background and Procedural History

In 1987, plaintiff, Mother Frances Hospital ("Hospital"), retired its 1983 series bonds by issuing, in replacement, $64,000,000.00 in 1987 series bonds. The

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[1] The initial defendant in this civil action was ex-Secretary of the Department of Health and Human Services, Louis W. Sullivan. The current Secretary is Donna Shalala. Under the Federal Rules of Civil Procedure, Rule 25(d), when a public official who is party to an action ceases to hold office, "the action does not abate and the officer's successor is automatically substituted as a party."

Hospital allegedly sustained a loss of $11,672,393.00,[2] and claimed $4,565,362.00 as the allowable amount to be reimbursed by the Department of Health and Human Services ("HHS"), through its program of Medicare. The Hospital argued that under General Accepted Accounting Principles ("GAAP"), it was due the full reimbursement in the year the loss was incurred. 1987. Blue Cross & Blue Shield, the intermediary for Medicare providers in Texas and for the Hospital, made audit adjustments that permitted only $824,727.00 as an allowable cost, reflecting amortization of the loss in future periods. The intermediary, rejecting application of GAAP, relied on Section 233 of the Provider Reimbursement Manual ("PRM 233"), published by the Secretary of HHS to aid in interpreting the Medicare regulatory provisions.

The Hospital, disagreeing with the intermediary's determination, obtained a hearing before the Medicare Provider Reimbursement Review Board ("PRRB"), in accordance with 42 U.S.C. § 1395oo. Reversing the decision of the intermediary, the PRRB found GAAP applicable, making the loss reimbursable in the year in which it was incurred, 1987. The Acting Administrator of the Health Care Financing Administration reversed the PRRB's decision and held that the loss must be amortized, and that

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[2] The Hospital borrowed new money in 1987, when interest rates had dropped, and placed it in an escrow account to pay the interest and principal on the old bonds, taken out in 1983, when interest rates were higher. Under this arrangement, in order to earn enough interest at the lower rates to continue making payments to bond holders, it is necessary to place a larger amount in the escrow account than the original principal. This caused the Hospital to sustain the loss at issue in this case.

the PRRB's reliance on GAAP was erroneous.[3] The Administrator, like the intermediary, found that PRM 233 was controlling. In compliance with 42 U.S.C. § 1395oo(f)(1), the Hospital sought judicial review of the final administrative decision of the Secretary to amortize the Hospital's loss.

This civil action was referred to the Honorable Harry W. McKee, United States Magistrate Judge, pursuant to 28 U.S.C. § 636(b), for proposed findings of fact, conclusions of law, and recommendations for the disposition of pending motions. The parties filed cross motions for summary judgment. The Magistrate Judge recommended that the Hospital's motion for summary judgment be granted, that the Secretary's motion be denied, and that the final decision of the Secretary to amortize the loss be reversed. In addition, the Magistrate Judge accepted the Hospital's claimed reimbursement costs, $4,563,362.00

A district judge is required to conduct a *de novo* review of objections to the report and recommendation filed by the parties, in accordance with 28 U.S.C. § 636. The district judge may accept, reject, or modify the report and recommendation, and may receive further evidence or recommit the matter to the Magistrate Judge.

It is determined from such *de novo* review that the Secretary's position, that Medicare reimbursement for the Hospital's loss be amortized, is both a permissible and reasonable interpretation of the applicable statute and

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[3] The Health Care Financing Administration ("HCFA"), pursuant to a delegation of authority from the Secretary of HHS, in accordance with 42 C.F.R. § 405.1875 *et seq.*, is responsible for implementing and administering the Medicare Act. The HCFA, under this authority, may reverse, affirm, or modify the PRRB's decision on its own motion. The HCFA's determination represents the final decision of the Secretary, from which judicial review may be sought. 42 U.S.C. § 1395oo(f)(1).

regulations. Hence, the Secretary's final decision to amortize the Medicare reimbursement for the loss on bond defeasance incurred by the Hospital should be approved and ordered reinstated.

II. Standard of Review – Deference to the Agency's Interpretation

Where the determination at issue involves the interpretation of a statute, an agency's interpretation of a statute it administers should be upheld if it is based on a "permissible" construction of the language of the statute. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc. et al.*, 467 U.S. 837, 843 (1984). Moreover, the agency's construction of a statutory scheme it adminsters need only be reasonable, and not the only interpretation or the one the court would have reached if it were initially faced with the question. *Udall v. Tullman*, 380 U.S. 1, 16 (1965); *Marcello v. Bowen*, 803 F.2d 851, 855 (5th Cir. 1986).

The agency has the authority, either explicit or implicit, to elucidate a particular statute by issuing regulations. *Chevron*, 467 U.S. at 843-44. Such regulations are to be given controlling weight unless they are "arbitrary, capricious, or manifestly contrary to the statute." *Id.* at 844.

Under these well-settled principles of deference to an agency's interpretation of a statutory scheme it administers, the question before the Magistrate Judge was whether the Secretary's interpretation of 42 U.S.C. § 1395(f)(b), the statutory authority for allowing reimbursement of "reasonable costs" to health care providers, was reasonable. Two of the regulations promulgated to elucidate the statutory scheme, 42 C.F.R. §§ 413.9(b) and 413.20, are applicable to the point at issue, and these regulations must be given controlling weight, unless they are "arbitrary, capricious, or manifestly contrary to the statute."

III. Analysis

In analyzing the statute and its implementing regulations, the salient point for consideration by the Magistrate Judge, and by this court, is whether the Secretary must follow GAAP in determining when to reimburse the Hospital's refinancing loss, or whether the Secretary may follow PRM 233, requiring amortization. The issue respecting the amount of the loss was not properly before the Magistrate Judge.

The Hospital argues that 42 C.F.R. § 413.20 requires General Accepted Accounting Principles to be applied, making the loss reimbursable in the year in which it was incurred. In addition, the Hospital argues that if PRM 233 is applicable, calling for amortization, then PRM 233 is a substantive provision, demanding notice and comment before promulgation, neither present in this case. The Secretary, in opposition, argues that § 413.20 does not require GAAP for cost reimbursement, but only for the maintenance of reports and records by health care providers. In addition, the Secretary takes the position that PRM 233 is an interpretative provision of its own regulation, specifically 42 C.F.R. § 413.9(b), not requiring notice and comment.

All parties agree that if GAAP applied, it was mandatory that the cost be claimed in the period in which the transaction took place, and, further, that the reimbursement for the full cost be paid within the same period.

A. The Secretary is not bound by GAAP in Determining When to Reimburse the Hospital's Refinancing Losses.

Title 42 U.S.C. § 1395f(b), the statutory authority for reimbursement of "reasonable costs" to health care providers, provides that a "reasonable cost" is the cost "actually incurred . . . and . . . determined in accordance with regulations establishing the method or methods to be

used." 42 U.S.C. § 1395x(v)(1)(A). All parties agree that, under 42 C.F.R. § 413.5, the refinancing costs of the Hospital are reimbursable as "reasonable costs." The disagreement involves the *timing* of such reimbursement.

The central regulation at issue here, 42 C.F.R. § 413.20, provides that:

> The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.

42 C.F.R. § 413.20(a).

The title of § 413.20, "Financial data and reports," appears in Subpart B of the regulations, which is entitled "Accounting Records and Reports." Other provisions of the regulation concern the frequency with which providers are to supply cost reports, record-keeping requirements for new providers, and continuing provider record-keeping requirements. Subsection (e) permits program payments to be suspended if a provider does not maintain adequate records.

It is clear from the plain language of 42 C.F.R. § 413.20, that no provision in any way supports the Hospital's position that GAAP applies to cost reimbursement principles. Rather, the express language of

§ 413.20(a) indicates that GAAP only applies to the maintenance of financial records and statistical data by providers. In fact, the general rules of cost reimbursement are set forth in 42 C.F.R. § 413.5, which makes no reference to GAAP. Indeed, 42 C.F.R. § 413.5(b)(4) states that there should be "sufficient flexibility in the methods of reimbursement to be used. . . ."

In addition, the Secretary publishes the Provider Reimbursement Manual ("PRM") to aid in the interpretation of regulations. While the PRM does not have the binding effect of law or regulation, it is "entitled to be given important significance." *Sun Towers v. Heckler,* 725 F.2d 315, 325 n. 16 (5th Cir.), *cert. denied,* 469 U.S. 823 (1984). PRM 233 explicitly addresses losses incurred through advance refunding and states that these losses should be amortized over the life of the refunded bonds. PRM 233.3 provides, in relevant part: "[t]he effect of [amortization] is to implicitly recognize any gain or loss incurred as the result of an advance refunding over the period from the date the refunding debt is issued to the date the holders of the refunded debt receive the principal payment, rather than immediately."

The Magistrate Judge rejected as illogical and unreasonable the Secretary's final decision to amortize the Hospital's loss. His report and recommendation stated:

> The Secretary is arguing that a provider's reimbursable costs will be determined under GAAP accounting, but actual reimbursement will take place according to another method. This is an unreasonable interpretation of the regulations. As reasonable costs must be calculated according to GAAP, it is only logical that the Secretary will reimburse providers under that system as well.

(Report and Recommendation, p. 8). The Secretary ob-

jected that the report and recommendation misstated the HHS's position. The Secretary did not argue that GAAP should be applied to reimbursable costs and not to Medicare reimbursement, for that construction would clearly violate the Fifth Circuit's holding in *Sun Towers,* 725 F.2d at 329, *quoting American Medical Int'l., Inc. v. Secretary of Health, Education and Welfare,* 466 F. Supp. 605, 623 (D.D.C. 1979), *aff'd,* 677 F.2d 118 (D.C. Cir. 1981) ("[42 C.F.R. § 413.20] is not a regulation affecting the substantive provisions of the program as to what constitutes reimbursable costs."). The Secretary, instead, interprets 42 C.F.R. § 413.20 to mean that the provider, in the exercise of its discretion, may choose to maintain its *own* financial records according to GAAP. This data can then be used to determine the reasonable costs on which Medicare reimbursement is based. (Defendant's Objections, p. 5). The Magistrate Judge's determination that the Secretary's position was unreasonable, having rested on a misinterpretation of the Secretary's argument, must be rejected.

Moreover, the Magistrate Judge's conclusion that GAAP must be followed in determining when to pay Medicare reimbursement is contrary to the Fifth Circuit's reasoning in *Sun Towers.* 725 F.2d at 328. In *Sun Towers,* the district court found that the regulation in question required that GAAP be used in determining whether certain costs and returns on equity capital were allowable costs under Medicare. The Fifth Circuit reversed the district court's determination, holding that 42 C.F.R. § 413.20 "only provides that accepted accounting principles be used in uniform record-keeping, not in determining costs allowable under the Medicare Act." and also holding that "[t]he regulation is directed at the type of financial data and reports required of its providers; *it is not a regulation affecting the substantive provisions of the program as to*

what constitutes reimbursable costs." Id. at 329 (emphasis supplied). Thus, although the report and recommendation is correct in noting that *Sun Towers* did not address the timing of reimbursement, the Fifth Circuit in *Sun Towers* upheld the Secretary's interpretation of § 413.20, that GAAP relates only to the type of financial data and reports required of providers. *Id.* at 329.

The report and recommendation cites with approval a case supporting the Hospital's position, *Ravenswood Hospital Medical Center v. Schweinker,* 622 F. Supp. 338 (D.C. Ill. 1985)[4], but it omits to mention a recent district court case which supports the Secretary's position, *Guernsey Memorial Hospital v. Sullivan,* 796 F. Supp. 283 (S.D. Ohio 1992), *appeal docketed,* No. 92-3563 (6th Cir. June 11, 1992) (argued March 2, 1993). The *Guernsey* court, explicitly considering the timing of Medicare reimbursement, held that 42 C.F.R. § 413.20 does not require that Medicare reimbursement be determined according to GAAP. *Id.* at 291. In referring to PRM 233, the *Guernsey* court found that the Secretary's method of amortization to reimburse a provider for the costs of advance refunding was reasonable. *Id.* Giving consideration to the Fifth Circuit's binding decision in *Sun Towers,* as well as to the recent district court decision, *Guernsey,* it is found that the Secretary's position is reasonable.

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[4] In *Ravenswood,* the district court concluded that amortization of a loss due to advance refunding is not an appropriate method of reimbursement for refinancing losses. However, it is arguable that *Ravenswood* is not directly applicable here, since the court was concerned with inconsistencies resulting from the Secretary's treatment of these losses under PRM § 215.1, the predecessor to PRM § 233. Moreover, the court in *Ravenswood* nowhere held that 42 C.F.R. § 413.20 requires that GAAP be followed.

B. Provider Reimbursement Manual Section 233

1. PRM 233 is Interpretive, Not Substantive

The report and recommendation of the Magistrate Judge accepts the Hospital's position that PRM 233, the provision requiring amortization of the loss, is contrary to 42 C.F.R. § 413.20, the regulation the Hospital alleges makes necessary reimbursement of the full loss in 1987. The report and recommendation found that GAAP was required under § 413.20, and also concluded that PRM 233 was a substantive provision, effecting a change in the rights of the parties, and thus void for lack of notice and public comment.

This finding must be rejected. Because it has been determined that GAAP does not apply to reimbursement of losses from refinancing, PRM 233 does not effect a change in the granting of substantive rights, and is therefore interpretive. *See Creighton Omaha Regional Health Care Corp. v. Bowen,* 822 F.2d 785, 791 (8th Cir. 1987) (provisions of Provider Reimbursement Manual and amendments thereto are "interpretive rules," not subject to the rulemaking process.). Since it is interpretive in nature, PRM 233 falls within the exception to the notice and comment requirements of the Administrative Procedure Act, 5 U.S.C. § 533 (b)(3)(A).

2. PRM 233 is a Reasonable Interpretation of the Secretary's Own Regulations

The Secretary's interpretation of its own statutory scheme must be accorded proper deference, and must be accepted as correct if reasonable, as stated above. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc. et al.,* 467 U.S. 837, 843 (1984); *Udall v. Tullman,* 380 U.S. 1, 16 (1965); *Marcello v. Bowen,* 803 F.2d 851, 855 (5th Cir. 1986). Regulations promulgated to clarify the statute must be given deference unless they are arbi-

trary and contrary to statutory language. *Chevron,* 467 U.S. at 844.

The Secretary publishes the Provider Reimbursement Manual to aid in the interpretation of regulations. As previously noted, the PRM does not have the binding effect of law or regulation, but it is "entitled to be given important significance." *Sun Towers,* 725 F.2d at 325 n.16. PRM 233 specifically applies to losses incurred through advance refunding and states that these losses should be amortized over the life of the refunded bonds. The Secretary contends that PRM 233 is interpretive of 42 C.F.R. § 413.9(b), which provides that the "reasonable costs" of reimbursement will be "determined in accordance with an accepted method of cost apportionment to be the *actual cost of services furnished to beneficiaries during the year.*" (Emphasis added.) The Secretary insists that, although the "loss" reported on the Hospital's financial records is for 1987, the patients treated in 1987 were not the only beneficiaries of the refinancing transaction from which the loss stemmed. The loss reported under GAAP on the Hospital's financial statement in 1987 reflects only the fact that the Hospital borrowed funds in 1987 to pay off bonds purchased earlier at a higher interest rate. However, this "loss," incurred to build larger, newer facilities, was for the long term benefit of the Hospital and its patients, not merely those treated in 1987. Thus, the Secretary argues that this loss is correctly reimbursed over the life of the original debt.

Once again, the report and recommendation fails to accord proper deference to the Secretary's interpretation of HHS's own statutory scheme. It cannot properly be said that 42 C.F.R. § 413.9(b), as interpreted by PRM 233, is arbitrary or capricious.

3. PRM 233 Does Not Violate the Accrual Method of Accounting

The report and recommendation accepted the Hospital's argument that PRM 233's requirement of amortization would violate the Secretary's regulations requiring the use of the accrual basis of accounting. *See* 42 C.F.R. § 413.24(a). (Report and Recommendation, p. 10). Under the accrual basis of accounting,

> revenue is reported in the period when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

42 C.F.R. § 413.24(b)(2). The report and recommendation asserts that amortization of the reported loss is contrary to accrual accounting, because the Hospital is no longer required to pay interest on the original bonds after they are defeased.

Amortization is not contrary to accrual accounting.[5] *See Stratanburg General Hospital v. Heckler,* 607 F. Supp. 635, 641 (D.S.C. 1985); Financial Accounting Standards Board Statement of Concepts No. 6.[6] The concepts under-

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[5] Although accrual accounting procedures contemplate the expensing of costs associated with items that provide no discernable future benefit, they also anticipate that, if any discernable future benefit exists, the costs will be capitalized and matched incrementally with future revenue or deferred to future accounting periods. *See Stratanburg General Hospital v. Heckler,* 607 F. Supp. 635, 641 (D.S.C. 1985) (affirming Secretary's decision to amortize certain costs associated with failed construction project); *Doctors Hospital, Inc. v. Califano,* 459 F. Supp. 201, 207-208 (D.D.C. 1978) (affirming Secretary's decision to disallow certain interest payments on money borrowed to obtain a permit to build new hospital until new facility actually built, and then requiring amortization of interest).

[6] This court may take judicial notice of the accrual method of accounting as a definitely ascertainable accounting method, capable of certain verification by resort to sources whose accuracy cannot

lying accrual accounting include allocation of costs to future periods when the benefits of these costs will be enjoyed in the future. *Id.* In this instance, the benefits of the refinancing transaction that led to the Hospital's loss will be enjoyed in the future. It does not follow that, merely because the Hospital paid the interest on the original bond issue to the trustee in 1987, it must be compensated for this cost in 1987. As the Secretary points out in HHS's objections to the report and recommendation:

> [T]he loss due to the advance refinancing transaction is the sum of certain expenses incurred because of long term debt of the hospital. The benefit of the original debt, as well as that of the lower interest rate on the refunded debt, will be enjoyed by future patients as much as it is enjoyed by patients treated in 1987. Therefore, under the accrual method of accounting the loss is appropriately amortized over the period during which the benefits will accrue.

(Secretary's Objections, p. 12).

Because a future discernable benefit appears probable, amortization in this case does not violate the accrual method of accounting set forth in 42 C.F.R. § 413.24(a).

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reasonably be questioned. *See Marquardt Company v. United States, 822 F.2d 1573, 1578 (Fed. Cir. 1987)* (taking judicial notice of "current accounting tests"); *Decker v. Korth* 219 F.2d 732 (10th Cir), *cert. denied sub nom Mullet v. Korth*, 350 U.S. 830 (1955) (same). *See also* Fed. Rule of Evidence 201 (b)(2); *McCormick on Evidence* §§ 328, 330 (1984); 9 Wigmore, *Evidence* § 2568(a) (1981) (a judge "is entitled to aid himself in reaching a decision [of the appropriateness of judicial notice], by consulting *any sources* of information that serve the purpose – official records, encyclopedias, any books or articles, or indeed any source whatever that suffices to satisfy his mind in making a ruling.") (original emphasis).

IV. The Report and Recommendation Adopting the Hospital's Claimed Loss as $4,565,362.00 Must be Rejected

The Magistrate Judge found that the total loss due to the refinancing transaction was $11,671,393.00, and that the total reimbursement effect on Medicare would be $4,563,362.00, if these costs were reimbursed in 1987 (Report and Recommendation, p. 16).

The only issue before the Magistrate Judge, as already set forth, was whether the Secretary must follow GAAP in determining when to reimburse the Hospital's refinancing loss, or whether the Secretary may deviate from GAAP, and amortize reimbursement of the loss under PRM 233. The issue regarding the amount of the loss was not properly before the Magistrate Judge. Based on a *de novo* review, it is found that there is no support in the record for the Magistrate Judge's finding that these amounts are correct, or that the issue was ever administratively adjudicated. Moreover, the Secretary never stipulated to these amounts, and HHS's representatives, in fact, stated numerous times at the hearing on the motion for summary judgment before the Magistrate Judge that HHS did not agree that this amount was correct (See Hearing Transcript, pp. 5-9).

V. Conclusion

Based on the foregoing analysis, the January 8, 1993, report and recommendation of the Magistrate Judge is rejected. The final decision of the Secretary of HHS to amortize the Medicare reimbursement for the loss on bond defeasance incurred by the plaintiff, Mother Theresa Hospital, should be approved, confirmed, and reinstated. Furthermore, the report and recommendation of the Magistrate Judge finding $11,671,393.00 to be the total loss resulting from the refinancing transaction, and further finding $4,563,362.00 to be the total reimburse-

ment effect should be determined by the appropriate agency within the Department of Health and Human Services.

A final judgment conforming to this memorandum opinion shall be entered contemporaneously herewith.

SIGNED this 23rd day of march, 1993.

/s/ Wm. Wayne Justice

WILLIAM WAYNE JUSTICE
United States District Judge

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

Civil Action No. 6:92 CV 337

MOTHER FRANCES HOSPITAL

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH AND HUMAN SERVICES

[FILED JAN 8, 1993]

REPORT AND RECOMMENDATION OF UNITED STATES MAGISTRATE JUDGE

This case presents the question of when Medicare must reimburse a hospital for costs incurred in the advance refunding of debt. Mother Francis Hospital (the Hospital) argues that the costs incurred are fully reimbursable in the period in which the transaction takes place; the Secretary argues that the costs must amortized.

The plaintiff, Mother Francis Hospital, brought this claim under 42 U.S.C. 1395oo(f)(1) for judicial review of the Secretary's decision to amortize the Hospital's loss on its advance refunding of debt. On August 5, 1992, the case was referred to this Court for proposed findings of facts, conclusions of law and recommendations for the diposition of pending motions pursuant to 28 U.S.C. 636(b). On

September 11, 1992, the plaintiff filed its motion for Summary Judgment. The defendant filed its Motion for Summary Judgment and Brief in Support of the Secretary's Decision on October 19, 1992. On November 25, 1992, the Court held a hearing on the parties' Motions. The Hospital was represented by Dan Peerrson, Esquire, Glenn Collins, Esquire, and Nick Alleman, Esquire. The Secretary was represented by Assistant United States Attorney Steve Mason. The parties having fully presented their position, the case is now ready for decision. *Flores v. Heckler*, 755 F.2d 401, 403 (5th Cir. 1985).

FACTS

In 1987 the Hospital engaged in a transaction called an advance refunding; an advance refunding occurs when a hospital borrows sufficient funds through a second bond issue to pay the old bonds at maturity. The Hospital's advance refunding took place in 1987 when it refinanced a 1983 bond issued by issuing $69,000,000 in new bonds, of which, $64,000,000 was used to refinance the 1983 bonds.

The new bonds issued by the Hospital were placed in an escrow fund with a designated trustee. The trustee then invested the funds in United States Treasury obligations at rates sufficient to pay the old bonds as they come due. The Hospital was discharged from its obligation on the old bonds, and the old bonds are no longer on the Hospital's books. The Hospital does not make payments of either principal or interest on the old bonds, these payments come from the trustee.

The Hospital benefits from the lower interest rates of the new bonds. However, the Hospital incurred a loss due to the greater principal needed to fund an amount sufficient to pay off the old bonds as they come due, and because of the transaction costs associated with the new bond issue. The cost of defeasing the old bond issue was

$11,671,393; the Hospital claimed reimbursable Medicare costs of $4,563,362.

To assist in the administration of the Medicare program, the Secretary is empowered to enter into agreements with third parties known as fiscal intermediaries. The intermediary acts as an agent of the Secretary for purposes of reviewing the providers claim for reimbursement. 42 U.S.C. 1395h. Blue Cross & Blue Shield of Texas, Inc. (the Intermediary) is the intermediary for Medicare providers throughout Texas, and specifically, is the intermediary for the Hospital. As a result of the advance refunding the Hospital reported a loss of $11,671,393. The Hospital claims it was entitled to Medicare reimbursement on the loss in the amount of $4,563,362. The Intermediary made audit adjustments requiring the Hospital to amortize reimbursement of the loss over the life of the old bonds. The Intermediary claimed that this adjustment was allowed by the Provider Reimbursement Manual, section 233.

The Hospital appealed the adjustment to the Provider Reimbursement Review Board (PRRB), challenging the propriety of the adjustment and seeking reimbursement for the entire loss in fiscal 1987. On February 13, 1992, the PRRB reversed the decision of the Intermediary, and found the Hospital was entitled to be reimbursed for the full loss in 1987. The PRRB held that Generally Accepted Accounting Practices (GAAP) was an accounting treatment which conformed with the regulations, and under GAAP, the loss was fully reimbursable in fiscal 1987.

The Administrator then reviewed the PRRB's decision. The Administrator reversed the PRRB's decision and held that the loss on advance refunding must be amortized. The Administrator stated that the PRRB mistakenly relied on

GAAP. The Administrator stated the PRM 233 controlled the situation, and under PRM 233, the loss should be amortized. The Hospital then appealed the Administrator's decision.

STANDARD OF REVIEW

This case involves an agency's construction of its own regulations. The courts defer to an agency's interpretation of its own regulations. *Marcello v. Bowen*, 803 F.2d 851, 855 (5th Cir. 1986) (citing, *E.I. DuPont de Nemours & Co. v. Collins*, 432 U.S. 46, 54-55 (1977)). Courts accept the agency's interpretation if it is reasonable in terms of the words of the regulations, even though, as an original matter, the court might have reached a different conclusion. *Id.*

STATUTORY AND REGULATORY FRAMEWORK

Under 42 U.S.C. 1395f(b), providers of health care are entitled to reimbursement of their "reasonable costs." "Reasonable cost" is the cost "actually incurred . . . and . . . determined in accordance with regulations establishing the method or methods to be used." 42 U.S.C. 1395x(v)(1)(A). In promulgating regulations, the Secretary must consider the principles generally applied by national organizations in computing the amount of payment. *Id.* An overriding consideration is that cross-subsidization not occur; cross-subsidization occurs when the costs of non-Medicare patients are borne by Medicare patients. *Id.*

Under this statutory grant of authority, the Secretary promulgated regulations which require that health care providers must compile cost data and that "cost data must be based on an approved method of cost finding and on the accrual basis of accounting." 42 C.F.R. 413.24(a).

According to the regulations:

> Under the accrual basis of accounting, revenue is reported in the period when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

42 C.F.R. 413.24(b)(2). For the proper determination of costs payable, providers must utilize "[s]tandardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields." 42 C.F.R. 413.20(a). The parties agree that the "standardized" language in 42 C.F.R. 413.29 calls for the use of GAAP; however, the parties disagree about the meaning of that section.

The Secretary has published the Provider Reimbursement Manual (PRM) to assist in the interpretation of the regulations; it does not have the binding effect of law or a regulation. In 1983 the Secretary promulgated PRM 233, which applies specifically to advance refunding transactions. The section states that costs incurred in the advance refunding of debt should be amortized over the life of the refunded bonds. The Intermediary relied on PRM 233 in requiring the Hospital to amortize the costs associated with the new bond issue. The Hospital objected on the ground that the PRM is contrary to the regulations and is therefore void.

The Secretary does not contest that the costs incurred in the advance refunding are reimbursable under Medicare. Defendant's Brief, p. 7. Instead, the Secretary argues that PRM 233 controls the timing of Medicare payments for losses on advance reimbursements, and so the costs must be amortized. The parties agree that the Hospital correctly reported the loss under GAAP. Defendant's Memorandum, p. 8. GAAP consists of the official publications of the Accounting Principles Board (APB) and the Financial

Accounting Standards Board (FASB) of the American Institute of Certified Public Accountants (AICPA). In 1972, the AICPA adopted APB Opinion No. 26. This opinion requires that the loss on bond refunding be taken in the year in which the loss is incurred.

DISCUSSION

The Secretary relies heavily on *Sun Towers v. Heckler,* 735 F.2d 315 (5th Cir. 1984), to support the Administrator's decision. The issue in *Sun Towers* was whether certain costs and returns on equity capital were allowable costs under Medicare. The *Sun Towers* court held that 42 C.F.R. 405.406, which is now 42 C.F.R. 413.20, did not require application of GAAP to determine costs allowable under Medicare. The Secretary argues that *Sun Towers* fully supports its interpretation of 42 C.F.R. 413.20 that providers must use GAAP in maintaining financial data and reports, but the Secretary need not follow GAAP for purposes of Medicare reimbursement.

The Secretary generally agrees with the Hospital's argument that Medicare reimbursement is a two step process: first, the provider's "allowable costs" are determined; then, from these allowable costs, the "reasonable costs" to be borne by Medicare must be determined. Defendant's Rejoinder, p. 4. The Secretary further agrees that the costs claimed by the Hospital are reimbursable. Defendant's Memorandum, p. 7. However, the Secretary states that both allowable costs and the proportions of those costs to be borne by Medicare are determined on the basis of costs allowable in a particular reporting period. Therefore, because an "allowable cost" is a cost which is allowable in a particular cost reporting period, the Secretary argues that the issue before this Court is identical to the issue in *Sun Towers.*

First, the Secretary's citation misses the point. The issue involved in this case is the *timing* of reimbursement of allowable costs; the issue in *Sun Towers* was whether certain costs were allowable. *Sun Towers*, 725 F.2d at 325. The Secretary has already admitted that the costs claimed by the Hospital are allowable. Defendant's Memorandum, p. 7. Second, the Secretary forwarded no evidence to show that the Hospital's $4,563,362 claim on its total loss of $11,671,393, is attributable to any year except 1987. Nor has the Secretary challenged the Hospital's claim of $4,563,362, it has merely challenged the requirement that it reimburse this amount in one period.

Since the Secretary admits that the costs claimed by the Hospital are reimbursable, the question now turns to when those costs will be reimbursed. The Secretary admits that the "standardized accounting practices" language in 42 C.F.R. 413.20(a) requires the application of GAAP. It argues, however, that the section merely states that a Hospital's use of GAAP need not be changed to participate in Medicare; the Secretary further argues that Medicare amounts payable will be determined using this information, but GAAP need not be applied in making payments under Medicare. Defendant's Memorandum, p. 13. The Secretary is arguing that a provider's reimbursable costs will be determined under GAAP accounting, but actual reimbursement will take place according to another method. This is an unreasonable interpretation of its regulations. As reasonable costs must be calculated according to GAAP, it is only logical that the Secretary will reimburse providers under that system as well.

This interpretation is further supported by the remaining language of section 413.20(a). The section states that: "Changes in these practices and systems will not be required in order to determine costs payable under the

principles of reimbursement." 42 C.F.R. 413.20(a). Therefore, GAAP applies to how and when the reasonable costs of providing care are paid. This proposition is further supported by the next sentence of the regulation: "Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basic accounts, as usually maintained." 42 C.F.R. 413.20(a). This language again clearly recognizes the use of GAAP for purposes of determining the amount of Medicare reimbursement payments.

The Hospital cites *Ravenswood Hospital Medical Center v. Schweinker*, 622 F.Supp. 338 (D.C. Ill. 1985), in support of its position. The issue involved in *Ravenswood* was whether the hospital could claim its entire costs of an advance refunding in the year of the transaction, or whether it must amortize the loss in accordance with PRM 215.1, the predecessor to PRM 233. The Secretary attempts to distinguish this case on the ground that PRM 215.1 accorded different treatment to gains and losses from the advance refunding of debt. The important difference between PRM 215.1 and PRM 233 in relation to the case at bar is that PRM 215.1 required amortization only when the debt cancellation costs exceeded 50% of the amount of interest cost and amortization expense that would have been allowed had the indebtedness not been canceled. However, the outcome of the case did not rest on this provision of PRM 215.1, and the reasoning of *Ravenswood* is applicable here.

As in the present case, in *Ravenswood* the Secretary admitted that according to GAAP a loss on advance refunding is incurred in the period in which it is defeased. Again as in the present case, the Secretary argued that amortization of the cost of defeasing the old bonds in *Ravenswood* was necessary to match the cost of providing services to the time the services are rendered. The *Ravenswood*

Court pointed out that the interest, premium, and refinancing expenses were paid and the loss was incurred in the year of the refunding. *Ravenswood*, 622 F.Supp. at 345.

The Court further stated that amortizing the costs would be inconsistent with Medicare's basic criteria of reimbursement, that is, Medicare reimburses providers for their reasonable and necessary costs or providing services. *Ravenswood*, 622 F.Supp. at 345. Therefore, applying that principle to the situation at hand, the court found the costs should be reimbursed in the year in which they were incurred, and found PRM 215.1 to be arbitrary and unsupported by regulation. *Id.; accord Baptist Hospital East v. Sullivan*, 767 F.Supp. 139, 141 (W.D. Ky. 1991). The Court finds the reasoning of *Ravenswood* applicable to the case at bar.

The Hospital also correctly argues that in this case amortizing the advance refunding costs violates the Secretary's regulations requiring the use of the accrual basis of accounting. 42 C.F.R. 413.24(b)(2). Under accrual accounting, expenses are reported in the period in which they are incurred. It is clear from the record that the Hospital will incur no expense from the advance refunding after the transaction takes place; the Secretary's own expert admitted that the Hospital would have no further interest expense, the old bonds would not be an obligation of the Hospital, and the old bonds would not appear on the Hospital's books. Rec. 679, 703, 705.

The Secretary forwards Financial Accounting Standards Board Statement of Concepts No. 6 in support of its argument. First, FASB Statement of Concepts No. 6 is not part of the administrative record. Therefore, it is not proper to consider it in deciding whether to uphold the Administrator's decision. *Bowles v. United States Army*

Corps of Engineers, 841 F.2d 112, 116 (5th Cir.), *cert. denied and appeal dism'd*, 488 U.S. 803 (1988), *transferred to Claims Court and summary judgment denied*, 23 Cl. Ct. 443 (1991).

However, even considering FASB Statement of Concepts No. 6, the Secretary's position is still incorrect. The Secretary correctly argues that according to Concept No. 6 accrual accounting requires the reported loss to be allocated over the years in which it is most closely related to the cost of providing health care. Statement of Concepts No. 6 states that: "Accrual is concerned with expected future cash receipts and outlays: it is the accounting process of recognizing assets or liabilities . . . expenses, . . . or losses for amounts to be received or paid . . . in the future." FASB Statement of Concepts No. 6, para. 141. Again, the expert testimony revealed that the Hospital would incur no expense on the old bonds once the new bonds were issued, the old bonds do not appear on the Hospital's books, and they are no longer an obligation of the Hospital. There is no evidence that the Hospital will incur an expense or loss on the bonds in the future; all of the evidence is to the contrary. Therefore, amortizing the cost of the advance refunding is contrary to the Secretary's regulation requiring accrual accounting and FASB Statement of Concepts No. 6.

The Administrator stated that because of the differing objectives of GAAP and Medicare, the use of GAAP may on occasion distort the cost of health services to Medicare patients. The cost to Medicare patients is not an issue in this case. The Secretary readily admits that the costs charged by the Hospital are valid. Defendant's Memorandum, p. 7. Therefore, this argument and the Administrator's citation of *Thor Power Tool Co. v. Commissioner*, 439 U.S. 522 (1979), to support the argument, are of no moment.

Further, there are important differences between the statute in *Thor* and that in the case at bar that render *Thor* inapplicable. In *Thor* the Supreme Court allowed the I.R.S. to deviate from a GAAP policy which the Commissioner found to be incompatible with income taxation policy. The statute in question stated:

> Taxable income shall be computed under the method of accounting on the basis which the taxpayer regularly computes his income in his books.

26 U.S.C. 446(a). However, in *Thor* there were no specific regulations requiring the use of GAAP. Further, the statute provided that if the method used by the taxpayer does not clearly reflect income, the computation of taxable income would be made under a method which in the opinion the Commissioner did clearly reflect income. *Thor*, 439 U.S. at 531. The statute and regulations in this case do call for the use GAAP in determining reasonable costs, and there is no allowance for the Secretary to choose a different method of accounting to determine reasonable costs. Therefore, *Thor* is inapplicable under the facts of this case.

The Administrator's opinion stated that the forward to the PRM allows the use of GAAP only in the absence of specific guidelines and PRM instructions. Administrator's Opinion, p. 5, n. 9. Therefore, argues the Administrator, because PRM 233 speaks directly to the present situation, it and not GAAP should be followed. This argument cannot stand.

First, the regulations themselves call for the use of GAAP. While the regulations which call for GAAP are not addressed directly to "advance refundings," they clearly apply in such a situation.

Second, the PRM does not have the force of law or a regulation. The Secretary readily admits this, as does the

Administrator in pointing out that the PRM is merely interpretive. Defendant's Memorandum, p. 29; Administrative Opinion, p. 2. Therefore, the PRM cannot change a regulation. Allowing it to do so would violate the Administrative Procedure Act (APA) as well as the Secretary's statutory mandate to promulgate regulations to determine a provider's reasonable reimbursable costs. 42 U.S.C. 1395x(v)(1)(A).

However, the Administrator held that PRM 233 is a rule which merely clarifies rather than changes the regulations, and as such is entitled to enforcement. The Hospital counters that if PRM 233 is a rule, then it is substantive and void since it was not promulgated in accordance with the notice and comment provisions of the APA. 5 U.S.C. 553.

Interpretive rules clarify or explain existing law or regulations; substantive rules grant rights, impose obligations or produce other significant effects on private interests. *American Hospital Assoc. v. Bowen,* 834 F.2d 1037, 1045 (D.C. Cir. 1987). If a rule does not define an ambiguous term or give an opinion regarding the meaning of the statute or regulations, but rather effects a change in the method used by the agency in granting substantive rights, then the rule is substantive. *Brown Express, Inc. v. United States,* 607 F.2d 695, 700 (5th Cir. 1979).

Under 42 U.S.C. 1395x(v)(1)(a), the Secretary must promulgate regulations to determine the reimbursable, reasonable costs under Medicare. By promulgating 42 C.F.R. 413.9 and 42 C.F.R. 413.20, the Secretary has done so. These regulations clearly call for the use of GAAP and do not need interpretation.

Putting this aside however, PRM 233 is a substantive rule in that it effects a change in the method used by the agency in granting substantive rights—the right to timely reimbursement of cost under Medicare. As previously

stated, 42 C.F.R. 413.20 requires the use of GAAP in determining when Medicare reimbursement for the advance refunding of bonds takes place. GAAP requires that the cost be claimed in the period in which the transaction takes place, and that reimbursement for the full cost be claimed in the period in which the transaction takes place. Therefore, the Secretary's attempt to alter the time of reimbursement with PRM 233 effects a change in the granting of substantive rights, and can be enacted only after notice and comment.

The Secretary attempts to save the validity of PRM 233 by asserting that it was promulgated through adjudication. This argument also fails.

The Secretary did not ever attempt to promulgate through adjudication the rule that reimbursement on advance refundings would be amortized over the life of the old bonds. The Secretary issued PRM 233 in 1983; it then attempted to apply that provision. No rulemaking by adjudication was ever intended or undertaken by the Secretary.

CROSS-SUBSIDIZATION

Cross-subsidization occurs when the costs of providing health care to non-Medicare patients is borne by Medicare payments, and is forbidden by the regulations. 42 C.F.R. 413.9(b). The Secretary argues that amortization of the loss would protect against cross-subsidization. Administrative Opinion, p. 9. This argument is not meritorious.

The parties stipulated that the testimony of four CPA's from similar proceedings would be included in the record. The experts agreed that no cost would be incurred by the provider in periods after the refunding. Mr. Leong, the expert for the Intermediary, testified that after the period of defeasance there would be no interest cost to the provider.

Rec. 703. He also testified that the provider's records would not reflect any costs in future periods, and the Hospital would incur no costs on the old bonds in the future. Rec. 679, 703, 705. Further, Leong testified that old bond holders have no recourse against the provider. Rec. 672. Therefore, the accounting methods required by the regulations and all of the evidence regarding the Hospital's obligation on the old bonds reveal that the costs of the advance refunding were incurred in 1987. The Secretary has forwarded no evidence which shows that the $4,563,362 out of the total $11,671,393 loss was attributable in any degree to non-Medicare patients.

The Secretary's argument in support of the Administrator's decision is purely speculative. The Secretary states that if the Hospital ceases to participate in the Medicare program, or *if the Hospital goes out of business,* or *if* the Hospital's ratio of Medicare to non-medicare patients decreases, then cross-subsidization would occur. Defendant's Memorandum, p. 26. By the same token, if the Hospital's ratio of Medicare to non-Medicare patients increases, then the Hospital would arguably be entitled to greater reimbursement from Medicare under the Secretary's interpretation. This speculative argument cannot support a decision to amortize a loss which under the regulations and GAAP should be claimed in the year of the transaction.

ECONOMIC REALITY

The Administrator held the loss was a cost of providing health care over several periods. Administrative Opinion, p. 9. Therefore, the Administrator held that amortizing the loss is in accord with the economic reality of the situation. The Administrator's economic reality argument fails.

The regulations state that cost data are to be based on the accrual method of accounting. 42 C.F.R. 413.24. Under the accrual method of accounting, "expenses are reported in the period in which they are incurred." Further, the regulations provide that GAAP applies to the reimbursement of allowable, reasonable costs. 42 C.F.R. 413.20. GAAP requires that the expenses of an advance refunding be claimed in the year in which the advance refunding takes place. APB Opinion No. 26.

The Secretary recognizes that under GAAP, losses associated with advance refunding are recognized in the year in which the transaction takes place. Defendant's Memorandum, p. 24. The Hospital's obligation on the old bonds ceases when the new bonds are issued, and the old bonds are written off of the Hospital's books in the year of the transaction. Further, the transaction costs occur in the year of the advance refunding. Therefore, under the accounting practices mandated by the regulations, the economic reality is that the loss is incurred in the year of the refinancing.

The Intermediary's expert, Leong, attempted to support the economic reality theory by stating that "the actuality of the situation is that the debt has not been liquidated." Rec. 679, 703. When asked to explain, he stated that the bondholders had not received their payments. Rec. 672. However, he admitted that there was no support in the regulations for the economic reality theory. Rec. 672.

RECOMMENDATION

Accordingly, it is recommended that the plaintiff's Motion for Summary Judgment be GRANTED, the defendant's Motion for Summary Judgment be DENIED, and the decision of the Secretary of Health and Human Services be REVERSED.

Failure to provide written objections to the proposed findings and recommendations contained in this report within ten days after service shall bar an aggrieved party from *de novo* review by the district court of the proposed findings and recommendations and from appellate review of factual findings accepted or adopted by the district court except on grounds of plain error or manifest injustices. *Thomas v. Arn*, 474 U.S. 140, 148 (1985), *Rodriguez v. Bowen*, 857 F.2d 275 (5th Cir. 1988).

SIGNED this 8th day of January, 1993.

/s/Harry W. McKee

HARRY W MCKEE
United States Magistrate Judge

APPENDIX E

HEALTH CARE FINANCING ADMINISTRATION

PRRB Decision No. 92-D11

IN THE CASE OF:

MOTHER FRANCES HOSPITAL, PROVIDER

v.

BLUE CROSS AND BLUE SHIELD ASSOCIATION/BLUE CROSS AND BLUE SHIELD OF TEXAS, INC., INTERMEDIARY

Dated: February 13, 1992

Claim for: Provider Cost Reimbursement Determination of Reasonable Costs for Cost Reporting Period(s) Ending June 30, 1987

DECISION OF THE ADMINISTRATOR

This case is before the Administrator, Health Care Financing Administration (HCFA), for review of the decision entered by the Provider reimbursement Review Board (PRRB). The review is during the 60-day period in § 1878(f)(1) of the Social Security Act, as amended [42 USC 1395oo(f)]. The Intermediary submitted comments requesting reversal of the PRRB's decision. On March 3, 1992, the parties were notified of the Administrator's

intention to review Issue No. 2 of the PRRB's decision concerning advance refunding. Comments were received from the Provider.[1] Accordingly, the case is now before the Administrator for final administrative decision.

ISSUE NO. 2 AND THE PRRB's DECISION

Issue No. 2 concerns whether reimbursement for a loss on bond refinancing should be governed by generally accepted accounting principles (GAAP) and, thus, subject to immediate payment by Medicare, or by HCFA policy, as expressed in the Provider Reimbursement Manual (PRM), which requires that it be amortized over a period of years. In this case, the Provider engaged in a defeasance transaction under which it extinguished liability on existing (refunded) debt and incurred liability on new (refunding) debt. As a result of this transaction, the Provider sustained a loss. The Provider then sought reimbursement for the entire loss incurred in the fiscal period in which the refinancing took place.

The PRRB held that the entire loss was allowable in the fiscal period in which the refinancing occurred. The PRRB

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[1] The Provider requested review of Issue No. 1. However, the Administrator elected not to review this issue which concerned whether and to what extent funds borrowed to construct a critical care facility were necessary, thus affecting allowable interest expense. The PRRB, in upholding the Intermediary's determination, held that the interest expense on loans made for capital purposes in this case is not allowable because the loan was not made to satisfy a financial need of the Provider. The PRRB found that these loans were not necessary because the Provider had sufficient funds available in its funded depreciation account for its capital asset acquisition needs, and the Provider did not adequately document that its funded depreciation was contractually committed. The PRRB also noted that the Intermediary's investment income offset adjustment was inappropriate in light of the disallowance of the interest expense at issue.

found that the loss on refunding met the criteria for an allowable cost under 42 CFR 413.9. Under GAAP, as enunciated in Accounting Principles Board (APB) Opinion No. 26, the entire cost of the bond refinancing should be recognized in the period of the transaction. The regulations at 42 CFR 413.20 and 413.24 require the application of GAAP to determine the amount of the cost and the timing of the loss. The use of GAAP is required in instances in which the Medicare program regulations do not specify the treatment of costs, as in this case.

The PRRB stated that the loss resulted from the decrease in the market value of that debt. Since this decrease was not recognized periodically, it should be recognized at the time of defeasance, similar to the treatment of an asset that is retired prematurely. The PRRB concluded that the Supreme Court's decision in *Thor Power Tool Co. v. Commissioner* (*Thor*), 439 U.S. 522 (1979), supports its conclusion that absent a specific regulatory instruction, Medicare program policy requires that GAAP must be followed. The PRRB referred to other court decisions in support of its decision.

SUMMARY OF COMMENTS

The Intermediary commented, urging reversal of the PRRB's decision, and referred to the Administrator's reasoning in prior decisions.[2] The Intermediary noted that

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[2] *Guernsey Memorial Hospital*, PRRB Decision No. 90-D50 and Administrator's Decision No. 90-D50; *see also Guernsey Memorial Hospital v. Sullivan*, CA No. C2-90-828 (S.D. Ohio, decision pending); *St. John's Regional Medical Center Group Appeal*, PRRB Decision No. 91-D76 and Administrator's Decision No. 91-D76; *see also St. John Hospital, et al v. Sullivan*, CA No. 92CV70067DT (E.D. Mich., decision pending); and *Graham Hospital Association*, PRRB Decision No. 91-D87 and Administrator's Decision No. 91-D87; *see also Graham Hospital Association v. Sullivan*, CA No. 92-1002 (C.D. Ill., decision pending).

the PRRB ignored the provisions of Section 233 of the PRM, which was in effect well before transaction in this case.

DISCUSSION AND EVALUATION

The entire record which was furnished by the PRRB concerning Issue No. 2 has been examined, including all correspondence, position papers, and exhibits submitted by the parties.[3] The PRRB's decision has been reviewed by the Administrator. All comments received after entry of the PRRB's decision have been made a part of the record and have been considered.

The underlying facts of this case are not in dispute. The Provider engaged in a defeasance transaction under which it extinguished its liability on existing ("refunded") debt and incurred liability on new ("refunding") debt. The proceeds of the refunding debt were placed with a trustee to be paid as required under the defeasance provisions of the transaction. As a result of the advance refunding transaction, the Provider sustained a loss, for which the provider sought reimbursement in full in the fiscal period in which the refinancing took place.

Under § 1814(b) of the Social Security Act [42 USC 1395f(b)], providers of health care services to Medicare beneficiaries are entitled to be reimbursed for the "reasonable cost" of the capital-related component of pro-

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[3] By Stipulation, dated August 6, 1991, the parties agreed to rely on the records accumulated in three prior PRRB cases: *Mercy Hospital*, PRRB Decision No. 89-D64, *Guernsey Memorial Hospital*, PRRB Decision No. 90-D50, and *St. Johns Regional Medical Center Group Appeal*, PRRB Decision No. 91-D76.

viding such services.[4] "Reasonable cost" is defined in the Social Security Act as "the cost actually incurred . . . and . . . determined in accordance with the regulations." [5] Those regulations must "consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment." One overriding requirement of the legislation and related regulations is that "the necessary costs of efficiency delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the cost with respect to individuals not so covered will not be borne by such insurance programs." [6] These principles are reiterated and further explained in the regulations at 42 CFR 413.9, which define reasonable cost.

In addition to the regulations, to assist intermediaries and providers in applying the reasonable cost reimbursement principles, the Provider Reimbursement Manual (PRM) has been published. The PRM is an extensive set of interpretative guidelines, which is updated continuously, and which provides more specific detail and clarification of the law and regulations for determination of reasonable cost. In the event there is no law or regulation specifically addressing Medicare reimbursement policy regarding a particular issue or situation, the PRM provides guidance in the proper interpretation and application of program policy.

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[4] The loss claimed by the Provider in this case is a capital-related cost, which, under the Prospective Payment System enacted on September 30, 1983, and effective for cost periods beginning October 1, 1984, is still reimbursed on a cost-basis. 42 CFR 412.1.

[5] Section 1861(v)(1)(A) of the Act [42 USC 1395x].

[6] *Id.*

In this case, there is no law or regulation which specifically addresses the treatment of bond refunding transactions for computing Medicare reimbursement. However, Medicare did have a specific policy in effect governing the treatment of refunding transactions. That policy, which is in § 233 of the PRM, was published in May 1983, and was effective for all cost reporting periods beginning on or after July 1, 1983. The refinancing transaction at issue in the instant case occurred in the fiscal period ending in June 30, 1987.

The effect of § 233 is to require the gain or loss on a refunding transaction to be spread over a number of years. This instruction is interpretative of 42 CFR 413.9, "Cost related to patient care," which requires payments to be based on "the actual cost of services rendered to beneficiaries during the year." Moreover, this policy accurately reflects the economic reality of a bond refunding on the cost of furnishing services to Medicare beneficiaries. Thus, proper application of this policy requires amortization of the refinancing loss.

In reaching its decision in this case, the PRRB relied exclusively on GAAP as determinative of Medicare program policy.[7] The Administrator finds, however, that the PRRB's reliance on GAAP is misplaced. When the Medicare regulations do not specifically address the method of calculating a particular cost, GAAP will usually provide a reasonably accurate calculation of the cost of

[7] GAAP consists of the official publications of the American Institute of Certified Public Accountants (AICPA). These official publications consist of Accounting Principles Board (APB) opinions, Financial Accounting Standards Board (FASB) Statements, and Accounting Research Bulletins ARB). In the event there is no official pronouncement, the consensus of the accounting profession, as manifested in textbooks, for example, determines GAAP.

delivering health services to a provider's patients. However, while GAAP can be useful in determining costs related to patient care, they are not necessarily controlling.

Section 1861(v)(1)(A) of the Act only required the secretary to "consider . . . the principles generally applied by national organizations." The Secretary is not required to adopt them for determining reimbursable cost.[8] Neither Congress nor the Secretary abdicated to the accounting profession the responsibility for determining Medicare reimbursement policy. Moreover, the Foreword to the PRM indicates that GAAP should be followed only in the absence of specific guidelines and instructions in the PRM.[9]

When the Medicare program was established in 1966, the official pronouncement of the American Institute of Certified Public Accountants (AICPA) on the accounting treatment of the early extinguishment of debt was Accounting Research Bulletin (ARB) No. 43. This ARB permitted a choice among three different methods for accounting for a loss upon the refunding of a debt: an immediate write-off, a write-off over the remaining contractual life of the old issue, or a write-off over the life of the new issue. The second method was regarded as "preferable." The reason given was "that when a cost is incurred the

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[8] *Spartanburg General Hospital v. Heckler*, 607 F. Supp. 635, 641 (D.S.C. 1985). *See also Sun Towers, Inc. v. Heckler*, 725 F.2d 314, 328-9 (5th Cir. 1984); *American Medical International, Inc. v. Secretary*, 466 F.Supp. 605, 624 n.21 (D.D.C. 1979), aff'd, 677 F.2d 118 (D.C. Cir. 1981).

[9] *See also* 41 *Fed. Reg.* 46292. "[G]enerally accepted accounting principles are applicable to Medicare cost determinations only when a cost situation is not covered by 20 CFR part 405 [recodified at 42 CFR Part 413] or the Provider Reimbursement Manual. It is only in the absence of health insurance program policy that generally accepted accounting principles should be followed."

benefits of which may reasonably be expected to be realized over a period in the future, it should be charged against income over such period." [10]

In 1972, the AICPA adopted APB Opinion No. 26. This opinion noted that the currently acceptable practice for treating a loss on refunding was to use one of the three methods listed above. The APB determined that the method should be standardized and selected the immediate recognition of gain or loss as the standard method. Several members of this APB, however, dissented to the opinion because they believed that it failed to recognize the economic effects associated with the refunding of debt. They reasoned that the usual economic effect of refunding at a lower interest rate is to reduce the periodic cash outlay in future periods; therefore, amortization over the unexpired term of the original issue reflects the proper periodic cost of borrowed funds.[11]

Moreover, as a result of the different objectives of GAAP and Medicare payment policy, the results of applying GAAP, on occasion, may distort the cost of the health services furnished to Medicare patients. The Supreme Court has likewise recognized that the objectives of GAAP are not always consistent with the objectives of government programs and that its use is not always appropriate. In the case of *Thor, supra*, the Court addressed the applicability of GAAP to calculate taxable income where a Treasury Regulation stated: "[T]he consistent application of generally accepted accounting principles . . .

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[10] *See* R. Wixon, W. Kell, and N. Bedford, *Accountants' Handbook*, 20.48 (5th Ed. 1970).

[11] APB Opinion No. 26, Assent of Mr. Gellein and Dissents of Messrs. Deflies, Watt, and Wear.

will ordinarily be regarded as clearly reflecting income." [12] The court wrote:

> "The primary goal of financial accounting is to provide useful information to management . . . and others properly interested; the major responsibility of the accountant is to protect these parties from being misled. The primary goal of the income tax system, in contrast, is the equitable collection of revenue; the major responsibility of the Internal Revenue Service is to protect the public fisc. Consistently [sic] with its goals and responsibilities, financial accounting has as its foundation the principle of conservatism, with its corollary that 'possible errors in measurement [should] be in the direction of understatement rather than overstatement of net income and net assets.' In view of the Treasury's markedly different goals and responsibilities, understatement of income is not destined to be its guiding light. Given this diversity, even contrariety, of objectives, any presumptive equivalency between tax and financial accounting would be unacceptable.
>
> . . .
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> "Finally, a presumptive equivalency between tax and financial accounting would create insurmountable difficulties of tax administration. Accountants long have recognized that 'generally accepted accounting principles' are far from a canonical set of rules that will ensure identical accounting treatment of identical transactions." [13]

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[12] Treas. Reg. 1.446-1(a)(2), 26 CFR 1.446-1(a)(2), quoted in *Thor, supra,* at 538

[13] *Thor Power Tool Co., supra* at 542-544. Citations omitted. *See also, Richey Manor, Inc. v. Schweiker,* 648 F.2d 130, 135 (D.C. Cir.

The Administrator finds the Court's analysis of the role of GAAP in the income tax system to be equally applicable to the Medicare cost reimbursement system. Under both the Internal Revenue Code and the Medicare Act, the respective departments have broad authority to determine the methods to be applied to implement their programs. While, under both programs, it is appropriate to consider GAAP, each department is required by statute to make an independent determination in each case whether the method of accounting reasonably reflects income or accurately determines the cost of rendering health care services to Medicare beneficiaries. Although the Internal Revenue Service and the Medicare program generally follow GAAP, they both have the right to apply a different method when necessary to satisfy their respective statutory goals, Thus, the principles concerning GAAP set forth by the Supreme Court in *Thor* are directly applicable to the Medicare program.

As noted in *Thor*, the primary purpose of financial accounting is to provide useful information to interested parties in order to protect them from being mislead. Consequently, financial accounting has as its foundation the principle of conservatism. This conservatism, which favors understatement of income, would, however, conversely produce an overstatement of costs. The requirement of APB No. 26 to recognize immediately the loss on refunding flows from this principle of conservatism. The

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1982), wherein the court said: "Accounting and legal principles appropriate in other contexts for other purposes have little persuasive force here because the question before us must be decided according to the Medicare regulations and the policies those regulations were designed to implement." Accord, *Gosman v. United States*, 573 F.2d 31, 41 (Ct. Cl. 1978) (pre-PRRB Medicare reimbursement case).

accountants' conservatism, however, cannot constrict the effort to determine accurate costs for Medicare reimbursement purposes.

Further, when evaluating whether it is appropriate to use GAAP for calculating Medicare reimbursement, one must consider whether GAAP will identify costs that are in economic reality borne by the provider, and if so, whether the costs are properly related in time to care being rendered to Medicare beneficiaries.[14] The economic realities of the case at hand demonstrate the superiority of amortizing the loss on defeasance, rather than allowing the full cost in the year of refinancing. The Provider was not required by the refinancing to make any immediate out-of-pocket payment to satisfy the refinancing loss. Instead, the loss was absorbed by the greater amount borrowed. Thus, the Provider has not actually experienced an immediate unreimbursed outflow of funds. Thus, reimbursement of the loss over a period of years will more accurately allocate the Provider's refinancing costs and, at the same time, more accurately reflect its current period costs.

In addition, while the Provider's obligation to repay principal on the original bond issue increased slightly with the refinancing, the overall interest obligation over the remaining term of the borrowing would decrease substan-

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[14] *Humana, Inc. v. Heckler*, 758 F.2d 696, 705, n.68 (D.C. Cir. 1985). *See also Doctors Hospital v. Califano*, 459 F. Supp. 201, 208-210 (D.D.C. 1978), affirming a PRRB decision disallowing a "loss" on the demolition of two buildings despite a regulation apparently allowing the loss, because the "economic realities of the transaction" were to increase the value of the underlying land more than the remaining value in the buildings.

tially. Medicare's recognition of interest, which is the cost incurred for the use of borrowed funds,[15] as an allowable cost in the years when accrued, would represent a substantial saving to both the Provider and the program. This savings would be spread over the fiscal periods from the date of the refinancing, until payment of the refunding bonds.

The Administrator recognizes that in situations in which the Provider refinanced its bond-related debt through a refunding transaction, even though the Provider improved its financial outlook, APB No. 26 advised it to recognize a loss on the refunding. This determination is the result of the APB limiting its concern to the treatment of the principal obligation. The Provider's net worth has been immediately reduced by the amount of the increased principal obligation, while the full reduction of its interest obligation will not be enjoyed until future periods.

Although immediate write-off of the loss may be a prudent financial reporting requirement, this loss is not a cost of providing health care services to Medicare beneficiaries in the year of the refunding. The loss was no more than an adjustment to the Provider's capital structure, which enabled the Provider to substitute less expensive financing for its existing, more expensive financing. Thus, the loss on the refinancing of the Provider's long-term debt did not relate exclusively to patient services rendered in the year of the loss. The loss is more closely related to the periods over which the original bond term extended (the period over which the lower interest will be enjoyed) than to the year in which the refunding occurred.

Finally, the statutory prohibition against cross-subsidization[16] requires that costs recognized in one

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[15] 42 CFR 413.153.

[16] Note 5, *supra*.

year, but attributable to health services rendered over a number of years, be amortized and reimbursed during those years when Medicare beneficiaries use those services. The U.S. Court of Appeals for the Eighth Circuit used similar reasoning in *Research Medical Center v. Schweiker*, upholding the Secretary's requirement that construction interest be capitalized. The court wrote:

> "The capitalization requirement of Sec. 206 of the Provider Reimbursement Manual attempts to implement the statutory requirement that Medicare costs not be borne by non-Medicare patients. Capitalization allows the Medicare reimbursement to change as the percentage of Medicare patients in a medical facility changes over the years. . . . If the interest expense were currently reimbursed, and [the provider] withdrew from the Medicare program shortly after the construction was completed, [the provider's] non-Medicare patients would benefit for many years from a Medicare reimbursement." [17]

Likewise, in *Gosman v. United States*,[18] the Court of Claims declined to use GAAP in favor of a Provider Reimbursement Manual instruction which required the cost of securing mortgage financing to be amortized and reimbursed over the life of the mortgage.

Accordingly, the Administrator finds that the loss is a cost of rendering patient care over several periods. By amortizing the loss to match it to Medicare utilization over the periods to which it relates, the program is protected from any decrease in Medicare utilization, and the Provider is likewise assured that it will be adequately reimbursed if

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[17] 684 F.2d 599, 603 (8th Cir. 1982).

[18] 573 F.2d, *supra* n.12.

Medicare utilization increases.[19] Further, the program is protected from making a payment attributable to future periods and subsequently having the Provider withdraw from the program before services are rendered to Medicare beneficiaries in those future periods.

In reaching a decision, the Administrator has also noted the reference to the Court decisions in the previous *Mercy* and *Baptist* cases by the provider and the PRRB. These cases involved refunding transactions that occurred before publication of the specific instructions in § 233 of the PRM.[20] The subsequent publication of § 233, however, clearly states Medicare program policy on these transactions and should be followed for all transactions occurring after publication of that PRM instruction in 1983. Section 233 of the PRM superseded § 215, and expressly applied to advance refunding of debt. It also requires any loss on the transaction to be amortized from the date of the refunding transaction to the date when the refunded bond principal is paid. This section was a clarification rather than a change of policy.[21]

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[19] Similarly, the court in *Spartanburg General Hospital v. Heckler*, 607 F.Supp. 635, 646 (D.S.C. 1985), held: "Capitalization [of certain planning costs] will result in the costs being reimbursed both at the time Medicare patients actually use the building and commensurate with the changing levels of Medicare utilization over the years. The court defers to the Secretary's policy choice, cognizant of her responsibilities as the steward of a public trust."

[20] Prior to publication of § 233, the only program instruction addressing early retirement of debt was § 215, which addressed early retirement of debt without refinancing. This policy recognized any debt retirement costs in the period of retirement, but also imposed a limitation on the amount of allowable debt retirement costs in any one period to the amount of costs related to the debt that would have been incurred had the debt not been retired.

[21] Section 233.1, PRM Transmittal No. 288, May 1983.

The Administrator notes that the PRRB relies heavily on its analysis of the Supreme Court's decision in *Thor, supra*, but disagrees with the PRRB's interpretation. In that case, the Supreme Court recognized the authority of the Internal Revenue Service (IRS) to interpret and rule on whether GAAP or agency policy more appropriately reflected the proper inventory valuation. The Court's discussion of this authority in the regulations was to emphasize the propriety of the agency's election not to follow GAAP.

The Court, in *Thor,* did not intend to set a standard whereby GAAP would blindly be followed. Otherwise, in the event of the lack of a specific statement of alternative authority to overrule GAAP, a clearly inappropriate, or arbitrary and capricious result could conceivably be reached. While GAAP is authoritative for accounting applications, it is not necessarily ideal for non-accounting applications. The Court did not condone such a result as it elevates form over substance.

The PRRB interprets *Thor* to require a specific regulatory authority to apply agency policy in place of GAAP. Thus, the PRRB claims that the Medicare regulations, principally 42 CFR 413.20, "do not appear to provide authority for the Administrator of HCFA to reject the use of GAAP. . . ." The PRRB concludes that the HCFA regulations at 413.20 and 413.24 contain much stronger language than the regulation in *Thor,* which merely provided that the consistent application of GAAP would *ordinarily* be regarded as clearly reflecting income unless the Commissioner decided otherwise. The PRRB concludes that the HCFA regulations, on the other hand, actually state "unequivocally" that costs must be determined according to GAAP. To conclude otherwise would "conflict directly with the plain language of 42 CFR 413.20."

The Administrator finds that the language in the regulations, in particular 42 CFR 413.20, does not support the PRRB's conclusion. 42 CFR 413.20, "Financial data and reports," upon which the PRRB relies, focuses primarily on provider recordkeeping requirements, rather than the timing for recognition of a cost as the PRRB alleges. This regulation requires only that "providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program." The regulation further indicates that Medicare will accept standardized reporting practices widely accepted in the hospital and related fields and not require changes in those systems to determine reasonable costs.

The Administrator finds that this language merely allows providers to continue using their preexisting accounting and reporting systems. Nowhere is it indicated that GAAP must be used by the Secretary or that GAAP will actually determine reasonable costs. The language provides only that the Secretary will "make use" of the data as usually maintained by the provider. No such reading of the language, as the PRRB proposes, can be construed as a commitment to accept the provider's data, in its format, as binding for reimbursement purposes. Moreover, the purpose of the regulation, as set forth at the conclusion of section (a), is "to arrive at an equitable and proper payment for Medicare beneficiaries." This objective further suggests that the Secretary has the discretion to modify the provider's data, if required, in order to achieve Medicare's stated goal.

Likewise, 42 CFR 413.24, "Adequate cost data and cost finding," addresses primarily recordkeeping requirements. This regulation states that "[p]roviders receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and

statistical records which must be capable of verification by qualified auditors." While this regulation does require reporting of costs on the accrual basis of accounting, it is not authority for the blanket application of GAAP. Reporting revenues and costs on the accrual basis is merely another method of recognition of costs, while GAAP is a far reaching set of financial reporting guidelines which include various cost recognition options, including the accrual basis of accounting.

Accordingly, the Administrator hereby holds that § 233 of the PRM is applicable to the Provider's bond refunding transaction. The effect is to amortize the loss on the advance refunding over those periods which benefit from the reduced interest rate.

DECISION

The decision of the PRRB as to Issue No. 2 is reversed. The Provider must amortize the loss on the advance refunding in this case in accordance the provisions in § 233 of the PRM. The decision of the PRRB as to Issue No. 1 is affirmed.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 3-30-92

/s/J. Michael Hudson

J. MICHAEL HUDSON
Acting Administrator
Health Care Financing Administration

APPENDIX F

PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

92-D11
CASE NO. 90-0463

PROVIDER – MOTHER FRANCES HOSPITAL TYLER, TX
PROVIDER NO. 45-0102

VS

INTERMEDIARY – BLUE CROSS AND BLUE SHIELD ASSOCIATION/BLUE CROSS AND BLUE SHIELD OF TEXAS, INC.

DATE OF HEARING – August 6, 1991

Cost Reporting Period Ended – June 30, 1987

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ISSUES:

1. Whether the Intermediary properly disallowed interest expense on the basis of its determination of excess borrowing.
2. Whether the Intermediary's adjustment to interest expense for the loss on advance refunding was proper. (On the Record)

SUMMARY OF FACTS:

The Provider is a 284-bed, acute care hospital. The Intermediary audited the Provider's cost report for the cost reporting period ended June 30, 1987, and issued a Notice of Program Reimbursement. The Provider appealed the Intermediary's reimbursable cost determination to the Provider Reimbursement Review Board (Board) under the provisions of 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of those regulations. The aggregate amount of Medicare reimbursement in controversy is approximately $4,068,000.

Issue 1 – Disallowance of Interest Expense:

Facts:

1. On March 1, 1987, the Provider borrowed $69,000,000 through issuance of revenue bonds (Tyler (Texas) Health Facilities Development Corporation Insured Hospital Revenue Bonds, Series 1987). Of the $69,000,000, the Provider borrowed $64,000,000 for the advance refunding of its outstanding bond issue (Tyler (Texas) Health Facilities Development Corporation Hospital Revenue Refunding Bonds, Series 1983), and it borrowed $5,000,000 to construct a critical care facility (Project) at the hospital.
2. At the time the Provider borrowed the funds, it had $8,600,000 in funded depreciation.

3. The Project was completed during FYE June 30, 1989, at a cost of $7,079,097.
4. The Intermediary disallowed the interest expense claimed for fiscal year ended (FYE) June 30, 1987, on the $5,000,000 borrowed for the Project based on its determination that the borrowing was not necessary under the provisions of 42 C.F.R. § 413.153(b)(2), because the Provider had $8,600,000 in funded depreciation. The amount of Medicare reimbursement in controversy is approximately $68,000.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's disallowance of interest expense on the $5,000,000 funds borrowed for the Project was not proper.

The Provider's contentions are summarized, as follows:

1. The Provider borrowed the $5,000,000 for its planned Project because the $8,624,000 amount available in funded depreciation was insufficient to pay for its other capital projects, for which it had committed and expended $14,900,000 at the time of the borrowing (Provider Addendum Exhibit I), in addition to the Project which was estimated to cost $7,000,000 over its two-year phased construction schedule (Provider Exhibits D and PH-13). During the course of the Project construction, the Provided expended for its other capital projects over $16,000,000 of funded depreciation, which is almost twice the amount of funded depreciation that was available during the period of construction of the Project.
2. The Provider claims it had a form of contract in place at the time it borrowed the $5,000,000 which committed the cost of the entire multi-phase Project, and not just the cost of the one component of the Project. The

Provider contends that its architectural invoices are evidence of contractual commitments (Tr. at 108). The Provider had incurred $53,508 for architects fees prior to March of 1987 (Provider Exhibit PH-22). As of June 30, 1987, the Provider's audited financial statements (Note 4, Property, Plant and Equipment) reported $133,000 construction in progress which included $58,000 for ICU Architect Fees (Provider Exhibits N and PH-3).

3. The Intermediary failed to adhere to the instructions regarding the commitment of funded depreciation outlined in Intermediary Administrative Bulletin (A.B.) 1186, which are applicable to the year in dispute (Provider Exhibit K). According to those instructions, "providers should be given *discretion* in the timing of the expenditures of funded depreciation" (A.B. 1186) (emphasis added). Those instructions indicate that a provider's "up front planning" for the capital project should be reviewed. The Provider contends it has demonstrated that the Project was part of an overall multiphase renovation which included the Labor & Delivery, Emergency Department, CCL/MRI, and Window Replacement/Wall Repair projects. The instructions in A.B. 1186 state that the determination of the necessity of borrowing should be made in the year the asset was placed in use. The Project was placed in use in FYE June 30, 1989. Therefore, the determination of unnecessary borrowing in FYE June 30, 1987, is inappropriate.

4. The Provider maintains that it documented its "up front planning" to borrow funds rather than use funded depreciation for the Project. The scope of the Project is contained in the Official Statement for the Series 1987 bonds (Provider Exhibit L), and its minutes of the

March 19, 1987 meeting of the Board of Directors describe the Project (Provider Exhibit PH-14). Cost estimates are detailed in the Project Statement of Probable Cost, dated March 4, 1987 (Provider Exhibit PH-16).

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it properly disallowed the interest expense on the $5,000,000 borrowed for the Project because the interest was not incurred on a loan that was made to satisfy a financial need of the Provider, as required by 42 C.F.R. § 413.153(b)(2).

The Intermediary's contentions are summarized as follows:

1. The Provider has not adequately documented that it had contractual commitments for its $8,600,000 of funded depreciation at the time it borrowed $5,000,000 for the Project.
2. The Provider did not submit substantive evidence of "up front planning," as required by A.B. 1186, to justify its decision to borrow rather than use funded depreciation for the Project.
3. Copies of minutes of meetings of the Provider's Board of Directors in the record do not provide evidence of the Provider's decision to borrow instead of using available funded depreciation for the Project (Tr. at 67).
4. The notes to the Provider's certified financial statements for 1987 refute the Provider's contention that the Official Statement for the Series 1987 bonds contains evidence of the Provider's contractual commitments for capital projects (Tr. at 53). The financial statements for 1987 identified only $133,000 construc-

tion in progress which included $58,887 for architectural fees for the Project (Provider Exhibits N and PH-22).

5. The Official Statement for the Series 1987 bonds is not a commitment to future projects. It is a document that describes for investors the projects for which funds are borrowed.

6. The Provider claims it spent $16,000,000 of funded depreciation on capital projects, other than the Project, after March 1987. However, those expenditures do not vitiate the Intermediary's finding that the $5,000,000 borrowing was unnecessary. Furthermore, the funded depreciation balance at June 30, 1989, the year in which the Project was completed, exceeded the March 1987 balance.

In conclusion, the Intermediary contends that the Provider has not adequately documented that the borrowing of $5,000,000 for a capital project at the time it had $8,600,000 available in funded depreciation was necessary pursuant to 42 C.F.R. § 413.153. Moreover, the Provider Reimbursement Manual (HCFA Pub. 15-1) Section 226C provides that funds are considered available unless contractually committed to the acquisition of depreciable assets or other capital projects related to patient care. The Provider has not demonstrated with substantial evidence that its $8,600,000 was contractually committed to the acquisition of capital projects, other than the Project, at the time it borrowed the $5,000,000. Therefore, the interest expense on the $5,000,000 borrowed funds claimed by the Provider for its FYE June 30, 1987, is unallowable because the borrowing was not necessary under the provisions of 42 C.F.R. § 413.153.

Issue 2—Loss on Advance Refunding (On the Record):

Facts:

1. The Provider appealed the Intermediary's determination on the basis that generally accepted accounting principles (GAAP) require that the loss on refunding of the Series 1983 bonds be taken in the FYE June 30, 1987, the year the advance refunding was completed. The amount of Medicare reimbursement in dispute is approximately $4,000,000.
2. The Provider issued $64,000,000 of its Series 1987 revenue bonds for the advance refunding of its outstanding Series 1983 bonds.
3. In its financial statements for FYE June 30, 1987, the Provider reported a loss on the advance refunding of $7,376,102 (net of the estimated third-party reimbursement effect) (Intermediary Exhibit 13).
4. The Provider did not claim any of the loss on advance refunding on its "as filed" cost report for its FYE June 30, 1987.
5. The Intermediary's adjustment added $824,727 to allowable cost, under the provisions of HCFA Pub. 15-1 § 233, Advance Refunding of Debt, to recognize that debt issue costs on the refunding debt must be amortized over the life of the refunding debt from the date the debt is incurred to scheduled maturity of the debt.
6. By the Joint Stipulation of the Parties, dated August 6, 1991, the parties agreed to rely on the record of the following cases submitted to the Board on this issue of loss on advance refunding, and incorporate the stipulation and its Exhibits A-D on testimony from those cases as part of the administrative record of this appeal:

Mercy Hospital (Portland, Maine) v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Maine, PRRB Case No. 86-0927, PRRB Decision No. 89-D64, September 26, 1989 (FYE 6/30/84);

Guernsey Memorial Hospital (Cambridge, Ohio) v. Blue Cross and Blue Shield Association/The Community Mutual Insurance Company, PRRB Case No. 88-1092, PRRB Decision No. 90-D50, April 16, 1990 (FYE 12/31/85); and

St. Johns Regional Medical Center Group Appeal v. Blue Cross and Blue Shield Association, Blue Cross and Blue Shield of Missouri, Aetna Life Insurance Company, and The Travelers Insurance Company, PRRB Case No. 88-0995G, PRRB Decision No. 91-D76, September 6, 1991 (FYs 1985-1988).

PROVIDER'S CONTENTIONS:

The Provider argues that, under Section 1861(v)(1)(A) of Title XVIII of the Social Security Act (Act), it is entitled to claim the entire loss incurred as a result of an advance refunding in the year the refunding occurred. Section 1861(v)(1)(A) of the Act requires the Secretary to promulgate regulations that interpret "reasonable costs" pursuant to "principles generally applied by national organizations." The regulation at 42 C.F.R. § 413.24(a) requires that cost data provided by hospitals "must be based on an approved method of cost finding and on the accrual basis of accounting." In addition, 42 C.F.R. § 413.20(a) requires that "[s]tandardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed." This regulation

requires that providers follow GAAP in the absence of a specific regulation. No regulation directly addresses treatment of a loss incurred on an advance refunding; therefore, the Provider relied upon GAAP pursuant to Paragraph 8 of Accounting Principles Board Opinion No. 26 (APB-26), published by the American Institute of Certified Public Accountants, which states:

> 8. *Recognition current in income.* [A] difference on refunding is similar to the difference on other early extinguishments and should be recognized currently in income in the period of the extinguishment.

The Provider notes that the Board previously decided this issue in *Mercy Hospital,* PRRB Decision No. 89D-64, *rev'd,* by Admin. Decision, (November 22, 1989), *rev'd, Mercy Hospital v. Sullivan,* No. 90-0024, slip op. (D. Me. April 25, 1991); *Baptist Hospitals v. Blue Cross and Blue Shield of Kentucky,* PRRB Decision No. 89-D65, September 26, 1989, *rev'd* by Admin. Decision, (November 22, 1989), *rev'd, Baptist Hospital East v. Sullivan,* No. 90-0059, slip op. (W.D. Ky. April 2, 1991); *Guernsey Memorial Hospital,* PRRB Decision No. 90-D50, *rev'd,* by Admin. Decision (October 16, 1990); and *St. Johns Regional Medical Center Group Appeal,* PRRB Decision No. 91-D76.

The *Mercy* court, reversing the Administrator's decision, quoted *Ravenswood Hospital Medical Center v. Schweiker,* 622 F.Supp. 338 (N.D. Ill. 1985). In *Ravenswood,* the district court noted that:

> The Secretary concedes that under Generally Accepted Accounting Principles, a loss on advance refunding is incurred in the period in which it is defeased. The Secretary argues nonetheless that 42

> C.F.R. Section 405.406(a) does not require that Generally Accepted Accounting Principles be followed when applying such principles is contrary to the purpose of the Medicare program. Although courts have recognized that 42 C.F.R. Section 405.406 may not be construed to require the Secretary to use a particular accounting method if it is inconsistent with the Medicare reasonable cost principles, the Secretary's insistence that amortization is necessary to match current costs of providing services to beneficiaries with services as they are rendered leads to inconsistencies which are irrational.

Ravenswood, 622 F.Supp. at 344.

The *Mercy* court emphasized that the law in this area is well established, stating that:

> The PRM's function is to serve as "a guide for intermediaries in applying the Medicare statute and reimbursement regulations and does not have the binding effect of law or regulation[.]" *National Medical Enterprises, v. Bowen,* 851 F.2d 291, 293 (9th Cir. 1988) (quoting *Phoenix Baptist Hosp. & Medical Center, Inc. v. Heckler,* 767 F.2d 1304, 1307 (9th Cir. 1985)). It "does not implement new substantive policy, but rather provides optional guidelines clarifying existing regulations . . ." *Id.* (quoting *John Muir Memorial Hosp., Inc. v. Schweiker,* 664 F.2d 1337, 1339 (9th Cir. 1981)).

Mercy at 17.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it properly relied on HCFA Pub. 15-1 § 233, Advance Refunding of Debt, to require that debt issue costs on the refunding debt must

be amortized over the life of the refunding debt from the date the debt is incurred to scheduled maturity of the debt. The Intermediary determined that no factual dispute exists in this case and that the Provider had acted prudently. The underlying question is whether the rule to be applied is HCFA Pub. 15-1 § 233 or GAAP.

The Intermediary asserts that in three relatively recent Board decisions on advance refunding of debt (*Mercy Hospital, Baptist Hospital Group,* and *Guernsey Memorial Hospital*) the Board held for the appealing provider and the Health Care Financing Administration (HCFA) Administrator reversed each decision. The Intermediary states that its position in this case relies heavily on the HCFA Administrator's analyses in those cases.

In support of its position, the Intermediary argues as follows:

1. The Intermediary contends that its adjustment was made in accordance with § 1814(b) of the Act under which providers of health care services to Medicare beneficiaries are entitled to be reimbursed for their "reasonable cost," as defined in § 1861(v)(1)(A) of the Act.
2. When the Medicare regulations do not specifically address the method of calculating a particular cost, GAAP will usually provide a reasonably accurate calculation of the cost of delivering health services to a provider's patients. However, while GAAP can be useful in determining costs related to patient care, they are not necessarily controlling. The language of § 1861(v)(1)(A) of the Act only requires the Secretary to "consider . . . the principles generally applied by national organizations." The Secretary is not required to adopt them for determining reasonable cost. Neither

Congress nor the Secretary abdicated to the accounting profession the responsibility for determining Medicare reimbursement policy.

3. For the fiscal year under appeal, Medicare did have a specific policy in effect governing the treatment of refunding transactions as set forth in HCFA Pub. 15-1 § 233. That policy is consistent with the preferred GAAP method under Accounting Research Bulletin (ARB) No. 43. Section 233 was published in May 1983 and was effective for all cost reporting periods beginning on or after July 1, 1983. The refinancing at issue in this case occurred subsequent to July 1, 1983.

4. Section 233.3 requires that debt issue costs on the refunding debt must be amortized over the life of the refunding debt from the date the debt is incurred to scheduled maturity of the debt. Furthermore, section 233.3 C requires that unamortized discounts or premiums (reduction of debt cancellation costs) and debt issue costs of the refunded debt must be amortized over the period from the issue date of the refunding debt to the date the holder of the refunded debt will receive the principal payment. The effect of section 233 is to require the loss on a refunding to be amortized over a number of years. This section is interpretive of 42 C.F.R. § 413.9, Cost Related to Patient Care, which requires payments to be based on the "actual cost of services rendered to beneficiaries during the year." This policy more accurately reflects the economic reality of a bond refunding on the cost of furnishing services to Medicare beneficiaries than does APB-26.

5. The underlying regulation to section 233 is 42 C.F.R. § 413.153, Interest Expense. When this regulation is reviewed in its entirety, there is no interpretation of

the regulation which would allow the total loss on advanced refunding to be considered as allowable interest expense in the year of refunding. The escrow and unamortized financing costs cannot be considered allowable interest expense within the meaning of 42 C.F.R. § 413.153.

6. Paragraph 8 of APB-26 approaches a loss on refinancing as an investment issue. An investment loss, however, is not an allowable cost under 42 C.F.R. § 413.9 or any other Medicare regulation, since such a loss is not a "cost related to the care of Medicare beneficiaries." Further, 42 C.F.R. § 413.153(b)(2) treats interest expense as an allowable cost, but requires that it be offset by investment income. Investment losses are relevant in determining the amount of allowable interest expense. Although a factor in determining net allowable interest expense, an investment loss itself is not an allowable cost, nor are operating losses. Characterizing the refunding loss as a "market adjustment" in the year of the refunding does not transform the loss into a cost incurred in furnishing patient care. If a loss is considered a realized market loss, it is not allowable. The treatment of a loss under 42 C.F.R. § 413.9 and HCFA Pub. 15-1 § 233 conceptually recognizes the loss as the "price paid" by the Provider to obtain more favorable future financing terms.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. *Law—Title XVIII of the Social Security Act:*

§ 1814(b) —Amount Paid to Providers
§ 1861(v)(1)(A) —Reasonable Cost

2. *Regulations – 42 C.F.R.:*

§ 413.5	– Cost Reimbursement – General
§ 413.9	– Cost Related to Patient Care
§ 413.20	– Financial Data and Reports
§ 413.153	– Interest Expense
§ 413.153(b)(2)	– Necessary

3. *Program Instructions – Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):*

§ 233	– Advance Refunding of Debt
§ 233.3	– Allowable Cost
§ 226	– Funded Depreciation

4. *Other – Publications of the American Institute of Certified Public Accountants:*
Accounting Principles Board Opinion No. 26
Accounting Research Bulletin No. 43

FINDINGS AND CONCLUSIONS:

The Board, after consideration of the facts, parties' position papers, evidence presented, testimony at the hearing, and post-hearing briefs, finds and concludes as follows:

Issue 1 – Disallowance of Interest Expense:

The Board finds that the interest expense on the $5,000,000 borrowed for the Project is not allowable under the provisions of 42 C.F.R. § 413.153(b)(2) because the interest was not incurred on a loan that was made to satisfy a financial need of the Provider. The Intermediary's adjustment is affirmed.

The Provider has not adequately documented that it had contractual commitments for its $8,600,000 of funded depreciation at the time it borrowed $5,000,000 for the Proj-

ect. Minutes of meetings of the Provider's Board of Directors do not provide evidence of the Provider's decision to borrow instead of using available funded depreciation for the Project. The Board finds that the Provider's architects fees incurred in FYE June 30, 1987, do not provide substantive evidence of a contractual commitment for the cost of the entire multi-phase Project. Moreover, the Official Statement for the Series 1987 bonds is not a document that purports to be a contractual commitment.

As provided in HCFA Pub. 15-1 § 226C, funds are considered available unless contractually committed to the acquisition of depreciable assets or other capital projects related to patient care. The Provider has not adequately documented that its $8,600,000 of funded depreciation was contractually committed to the acquisition of capital projects, other than the critical care facility project, at the time it borrowed the $5,000,000.

Therefore, the interest expense on the $5,000,000 borrowed funds is not allowable under the provisions of 42 C.F.R. § 413.153 because the borrowing was not necessary.

The Intermediary's adjustments incorrectly offset a total of $2,444,882 of interest income. The Provider's post-hearing brief indicates that the Intermediary has verbally agreed to reopen the 1987 cost report to correct the offset of interest income for everything except the difference in the bond interest income of $576,325 ($1,680,330 total interest income less $1,104,005 total interest income on bond funds). Inasmuch as the Board finds that the interest expense on the $5,000,000 borrowed funds is unallowable, the Provider's interest income on the $5,000,000 borrowed funds should not be offset against interest expense.

Issue 2 – Loss on Advance Refunding (On the Record):

The Board finds that the Provider is entitled to take the full loss on the advance refunding of the Series 1983 bonds in FYE June 30, 1987. The Board finds that the loss on defeasance is an allowable cost under 42 C.F.R. § 413.9 and is to be reimbursed in its entirety in the fiscal year at issue. The Intermediary's adjustment is reversed.

Under GAAP, the loss on defeasance was a cost incurred in fiscal year 1987, an accounting treatment conforming with the regulations at 42 C.F.R. § 413.20 requiring providers to follow standardized accounting practices; and 42 C.F.R. § 413.24 requiring providers to furnish adequate cost data based on the accrual method of accounting. In particular, 42 C.F.R. §413.9 requires that all payments to providers of services must be based on the reasonable cost of services and related to the care of beneficiaries. As provided by 42 C.F.R. § 413.9, necessary and proper costs are costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities and are usually costs which are common and accepted occurrences in the field of the provider's activity. Thus, the Board holds that the Provider has submitted substantial evidence that the loss on defeasance meets these criteria, i.e., that it was reasonable, related to patient care, a necessary and proper cost, and a common and accepted occurrence in bond financing in the hospital industry.

By stipulation, the testimony of two accounting experts who had appeared before the Board for the providers in the *Mercy* and *Guernsey* hearings was incorporated into the record of this case. Analyzing pertinent Medicare regulations, the provider's witness in *Mercy* concluded that there was no basis to apply section 233, since its function

was to minimize Medicare reimbursement. In the instant case, the Provider's treatment of the loss – immediate recognition in FYE June 30, 1987 – flowed directly from the Medicare regulations mandating the use of GAAP. The *Guernsey* witness testified that HCFA Pub. 15-1 § 233.3 requires the Provider to treat the refunded debt as though it were still on the Provider's books, a policy the Intermediary contends reflects its position in this case.

The Intermediary's central argument is that because there is nothing in the Medicare regulations that identifies a loss on extinguishment of debt as an allowable cost, the Intermediary must first analyze the "loss" against 42 C.F.R. § 413.9 to determine if it is allowable. The Intermediary further argues that the Provider's use of GAAP would turn a claimed cost – which it determined to be non-allowable because it did not fall under any of the general or specific categories of allowable cost – into a reimbursable cost just because it may be permissible under GAAP to reflect the item in a provider's financial statement. In other words, Medicare reimburses providers for specific cost items, not anything that appears as a debit entry on a provider's income statement.

The Board rejects the Intermediary's arguments and stresses that it is not turning an allowable cost into a reimbursable cost merely because it is permissible under GAAP to reflect the loss in the Provider's financial statement. The Board emphasizes that it accepts the Provider's treatment because it believes that the cost, as incurred, is allowable under 42 C.F.R. § 413.9 – the cost was reasonable, necessary and proper, and related to patient care. Upon deciding that the refinancing was prudent, the Provider had little flexibility regarding the methodology and attendant costs, which are common and accepted occurrences in the health care field, the area of the Provider's activity.

Hence, the Board finds that the refinancing costs were necessary and proper costs as defined in 42 C.F.R. § 413.9(b)(2).

The loss was related to patient care in 1987, the year of defeasance. The Board finds that the loss resulted from a change in the current market value of the debt. Market value of debt is determined by the market rate of interest. Had the market value of the debt been recorded in the Provider's books as the market rate of interest fluctuated, the changes in the market value of the debt would have been recorded periodically as losses or gains. There would have been no loss on the extinguishment of the debt. For that reason, the entire loss on defeasance should be recorded when the bond contract is terminated, because it relates to past periods when the bond contract was in effect.

Stated differently, if, when the bonds were issued, it had been known that they would be defeased in 1987, the annual cost associated with those bonds, i.e., interest and bond discount and call premium amortization, would have been adjusted so that the maturity value of the debt would equal the reacquisition price. Thus, no difference upon early extinguishment would have occurred because previous periods would have borne the proper interest expense. This rationale is also supported by GAAP, as outlined in APB-26 on early extinguishment of debt.

This treatment is similar to that which occurs when a fixed asset is disposed of and replaced before the end of its estimated useful life. Any loss on disposal is clearly related to the old asset and not the replacement. The loss results from the fact that the actual depreciation in value of the asset differs from that recorded on the books. For that reason, the loss on disposal is treated as an allowable cost

in the year of the disposal. Similarly, a loss on defeasance should be treated as an allowable cost in the year of defeasance.

The Administrator has reversed the Board on the same issue in three prior cases: *Baptist, Mercy,* and *Guernsey.* In *Baptist* and *Mercy,* the Administrator discussed the Supreme Court's analysis of the role of GAAP in the income tax system in *Thor Power Tool Company v. Commissioner of Internal Revenue,* 439 U.S. 522 (1979). The Administrator concluded that analysis was applicable to the Medicare cost system. The facet of *Thor* the Administrator relied upon was the Court's discussion of the differences in the primary goals of two systems with distinctly differing purposes: the financial accounting and the income tax systems. In the Court's opinion, given the diversity of objectives, any presumption of equivalency between the financial accounting and tax systems would be unacceptable.

One of the governing regulations in *Thor* had provided that "[a] method of accounting which reflects the consistent application of Generally Accepted Accounting Principles . . . *will ordinarily be regarded* as clearly reflecting income." *Thor,* 439 U.S. at 537 (emphasis added). This same regulation also provided that "*no method of accounting is acceptable unless, in the opinion of the Commissioner, it clearly reflects income.*" *Thor,* 439 U.S. at 541 (emphasis added). Yet another governing regulation provided that an inventory taken in conformity with best accounting practice "can, *as a general rule,* be regarded as clearly reflecting . . . income." *Thor,* 439 U.S. at 537 (emphasis added). The plaintiff argued that these regulations created a *presumption* that accounting for inventory in accordance with GAAP was valid for income tax purposes. The plaintiff then argued that as long as the taxpayer used

GAAP, the burden shifted to the Commissioner to demonstrate that the taxpayer's method did not reflect income clearly. The court rejected this position, stating in part that "[w]e believe . . . that no such presumption is present. Its existence is unsupportable in light of the statute, the Court's past decisions, and the differing objectives of tax and financial accounting." *Thor* 439 U.S. at 785.

However, in contrast to the tax code, the Medicare regulations, principally 42 C.F.R. § 413.20, do not appear to provide authority for the Administrator to reject the use of GAAP to determine actual cost:

> The principles of cost reimbursement will require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the programs. *Standardized definitions, accounting, statistics, and reporting practices which are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement.* Essentially the method of determining costs payable under Title XVIII involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.

42 C.F.R. § 413.20 (emphasis added).

In addition, 42 C.F.R. § 413.24 provides that "the cost data submitted *must* be based on the accrual basis of accounting which is recognized as the *most accurate basis for determining costs*" (emphasis added).

In sum, these regulations together require that:

- Widely accepted accounting practices are followed;
- No changes in these practices will be required in order to determine cost; and
- The accrual basis of accounting is the most accurate basis for determining cost.

This language is much stronger than that in *Thor* which, indicated above, merely provided in part that the consistent application of GAAP would *ordinarily* be regarded as clearly reflecting income unless the Commissioner decided otherwise. Moreover, these Medicare regulations do not appear to provide the kind of authority for the Administrator to reject the use of GAAP for determining actual cost that the Supreme Court found in *Thor*. In fact, the Medicare regulations appear to go beyond those at issue in *Thor* in providing not merely a presumption but an actual requirement that determination of costs conform to GAAP. Indeed, the Board believes that these regulations, taken together, go far beyond requiring GAAP for mere recordkeeping, but instead appear to State unequivocally that *cost* shall be determined according to GAAP.

In emphasizing the Supreme Court's analysis of the *role* of GAAP in the income tax system and applying that to Medicare cost reimbursement, the Administrator effectively omitted an analysis of the actual content and wording of the Medicare regulations – an analysis which the Supreme Court had performed in *Thor*. The only law relied on by the Administrator, in addition to the manual provisions at issue, is that part of § 1861(v)(1)(A) of the Act which prohibits cross-subsidization.

Essentially, the principle of cross-subsidization assumes that the "cost" of a service has already been determined

and merely prohibits allocating or attributing that cost to the wrong subset of patients. The same statute that prohibited cross-subsidization provided that the reasonable cost of any service was the cost actually incurred excluding unnecessary costs. The statute also said that in prescribing regulations on payment, the Secretary must consider, among other factors, the principles generally applied by national organizations in computing the amount of payment. Although many regulations implemented this statute, the principle rules relevant to this decision are 42 C.F.R. §§ 413.9, 413.20 and 413.24.

Although 42 C.F.R. §§ 413.20 and 413.24 address the process of determining actual cost, 42 C.F.R. § 413.9 places a substantive limitation on the reimbursement of actual cost, providing that all payments to providers of services must be based on the reasonable cost of services and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs. These regulations, at least on their face, would appear to indicate that the actual cost of an item or service would be determined under 42 C.F.R. §§ 413.20 and 413.24 while the allowability of the cost would be determined under § 413.9. The Administrator, in reversing *Baptist* and *Mercy,* does not address this distinction directly, stating that "[t]he statutory prohibition against cross-subsidization requires that costs recognized in one year, but attributable to health services rendered over a number of years, be amortized and reimbursed during those years when Medicare beneficiaries use those services." *Mercy Hospital*, Admin. Decision at 10.

To illustrate this interpretation of cross-subsidization, the Administrator relied on the issue addressed in *Research Medical Center v. Schsweiker*, No. 81-2364 (8th Cir. Aug. 9, 1982), quoting that Court: "The capitalization requirement of Section 206 of the Provider Reimbursement

Manual attempts to implement the statutory requirement that Medicare costs should not be borne by non-Medicare patients." *Mercy Hospital*, Admin. Decision at 10 (footnote omitted). In substance, the Administrator states that 42 C.F.R. §413.9, with regard to costs related to the care of beneficiaries and cross-subsidization, encompasses both a substantive element (i.e., what is the nature of the item or service?) and a timing element (i.e., to what year does the service apply?). The Board does not agree with this analysis.

Timing must be determined in the context of 42 C.F.R. § 413.20, i.e., standardized methods of accounting for those costs and 42 C.F.R. § 413.24, i.e., expenses are reported in the period in which they are incurred, regardless of when they are paid. Any other interpretation would conflict directly with the plain language of 42 C.F.R. § 413.20. In her decision, the Administrator does not address this issue directly.

The third principle relied on by the HCFA Administrator is economic reality. The Administrator argues that economic realities demonstrate the superiortiy of amortizing the loss on defeasance rather than allowing the full cost in the year of refinancing, as set forth in APB-26. The problem with this approach is that, while beguiling, it is not a principle embodied in any regulation nor is it required by statute. The governing statute did not say that actual cost would reflect economic reality, and nowhere does the Secretary define economic reality: not in regulation, manual provision, intermediary letter, or any other publication. Further, HCFA has consistently rejected the concept of economic reality argued by providers in cases regarding recapture of depreciation. In both old and amended versions of the regulation providing for recapture of depreciation, HCFA has adopted a policy treat-

ment which coincides with that of GAAP. The Administrator of HCFA rejected the economic reality of reimbursable wear and tear on depreciable assets. The Administrator also rejected the fact that, as an economic reality resulting from the law of supply and demand, a gain on sale of an asset could be completely unrelated to the accumulated depreciation and the actual physical wear and tear on the asset. Thus, the Administrator is inconsistent in the acceptance of, and the approach to, the concept of economic reality.

Therefore, it is clear that if, in the absence of any defining regulation, a concept of economic reality was used to measure costs, the result would be a reimbursement policy in which each provider and intermediary would apply their own personal concept of economic reality. The wisdom of adopting some common measurement of costs such as GAAP (which the Secretary appears to have done in 42 C.F.R. § 413.20) is self-evident. The principles of GAAP are carefully defined and are less open to interpretation than an undefined concept of economic reality. Indeed, for purposes of sound policy it is preferable to have Medicare reimbursement principles based on a consistent, "uniform standardized method of accounting," even if that method, GAAP, was historically developed to assure uniform financial reporting.

We acknowledge that the Secretary can and may have provided for specific exceptions to GAAP through regulation. However, the Secretary has not done so regarding this issue.

In the Board's previous decisions in *Baptist* and in *Mercy*, the Board adopted the analytic approach set forth in *Charlotte Memorial Hospital and Medical Center v. Bowen*, 860 F.2d 595 (4th Cir. 1988). The Fourth Circuit

Court in *Charlotte* affirmed the district court's holding that the Secretary's regulatory interpretations are inconsistent with the regulation requiring the application of accrual accounting and providing that a hospital should receive reimbursement when it incurs a cost. *Id.* at 597. Moreover, according to the Fourth Circuit:

> Even if the Secretary, in the absence of an enabling regulation, is authorized to prescribe regulatory interpretations that conflict with GAAP, a proposition we do not decide today, the Secretary would be at the very limit of his authority in doing so. Accordingly, such interpretations would be subject to greater scrutiny than interpretations which are consistent with GAAP.

Id. at 600.

In *Mercy,* the U.S. District Court for the District of Maine concurred with the court's finding in *Charlotte* that the provisions of HCFA Pub. 15-1 which are at issue:

> [C]ut against the tenor of the applicable regulation, 42 C.F.R. § 413.24. The interpretations, in addition, conflict with the GAAP approach. The Court therefore sets these interpretations aside and applies the GAAP approach to the instant case. *Charlotte Memorial,* 860 F.2d at 602.

Mercy, slip op. at 16.

Thus, for purposes of *Mercy,* the court concluded "that the Secretary's PRM 'clarifications' are contrary to the applicable regulations and impermissible under the APA [Administrative Procedures Act]." *Mercy,* slip op. at 16-17. The *Mercy* court notes that the Secretary relied on the IRS arguments in *Thor.* However, the IRS had no specific regulations in place requiring conformance with GAAP. That was not so in *Mercy.*

In *Mercy* the court found the reasoning in *Charlotte* persuasive and reached the same conclusion that amortizing the costs in dispute would fail to take account of the real costs immediately incurred by the hospital as a result of the advance refunding. The court found that the Secretary did not show by substantial evidence that the Medicare regulations cited (42 C.F.R. §§ 413.5 and 413.9) mandate amortization in order to match costs with Medicare reimbursement.

The court affirmed the Board's position in *Mercy*. The court's conclusions are quoted as follows:

> Given the absence of regulations specific to advance refunding, the presence of regulations regarding the applicability of GAAP, the limitations of PRM [HCFA Pub. 15-1] interpretations and the current APB pronouncement on GAAP methodology, I find the Secretary's position arbitrary and capricious and unsupported by substantial evidence on this record.

Mercy, slip op. at 22.

In conclusion, the Board finds that the Provider's use of GAAP in reporting a loss on the advance refunding of debt is correct. The Board holds that the loss is allowable under 42 C.F.R. § 413.9, and it conforms to the requirements found in 42 C.F.R. §§ 413.20 and .24 that actual cost be determined using standardized methods of accounting and the accrual basis of accounting.

DECISION:

Issue 1 – Disallowance of Interest Expense:

The Intermediary properly disallowed interest expense on the basis of its determination of excess borrowing. The Intermediary's adjustment to disallow interest expense is af-

firmed. However the Intermediary's erroneous interest income offset of $2,444,885, regarding the $5,000,000 borrowed funds is reversed.

Issue 2—Loss on Advance Refunding (On the Record)

The Provider is entitled to recognize the entire loss incurred in an advance refunding as an allowable cost in the year of the refunding. The Intermediary's adjustment is reversed.

Board Members Participating:

Jack Martin
Keith E. Braganza
Sally A. Kirkpatrick

FOR THE BOARD:

FEB 13 1992

/s/Jack Martin
JACK MARTIN
Chairman

APPENDIX G

Section 233 of the Secretary's Provider Reimbursement Manual provides as follows:

ADVANCE REFUNDING OF DEBT

233.1 *General.* – Advance refunding is a refinancing technique which enables a provider to replace existing debt prior to its scheduled maturity with new debt. This section does not apply to a recall of debt before scheduled maturity without the issuance of new debt. (See § 215, Recall of Debt Before Maturity.) Advance refunding is done for a variety of reasons including achieving a lower interest rate, improving cash flow, removing restrictive covenants, and increasing borrowing capacity. Sections 233.1-233.5 are effective for all refunding initiated on or after July 1, 1983. For purposes of this section, the term "initiated" means either (1) an action taken by the provider which reflects a clear intention to effect the advance refunding (e.g., board resolution empowering the management to proceed with the advance refunding, engagement of an underwriter, application to the debt-issuing authority, etc.), or (2) an official action by the debt-issuing authority reflecting a clear intention to effect the advance refunding.

233.2 *Definitions.* – For purposes of this section the following definitions apply:

Refunding Debt. – New debt issued to provide funds to replace the refunded debt immediately or at a specified future date(s).

Refunded Debt. – Debt for which payment immediately or at a specified future date(s) has been provided by the issuance of refunding debt.

Advance Refunding.—A transaction in which refunding debt is issued to replace the refunded debt immediately or at a specified future date(s).

Defeasance Provision.—A provision in the refunded debt instrument that provides the terms by which the debt may be legally satisfied and the related lien (if any) released without the debt necessarily being retired.

Defeasance.—Legal satisfaction of debt under the terms of a defeasance provision.

233.3 *Allowable Costs.*—When a provider defeases or repurchases debt incurred for necessary patient care through an advance refunding, the revenues and expenses associated with the advance refunding are treated as follows:

A. Debt issue costs on the refunding debt must be amortized over the life of the refunding debt from the date the debt is incurred to scheduled maturity of the debt. (See §§ 204, 206, 210, and 212.1.)

B. Debt cancellation costs on the refunded debt are allowable as indicated below:

1. Redemption expenses and any other miscellaneous expenses (legal fees, initial trustee fees, feasibility studies, stamp fees, printing, etc.) are allowed as paid or accrued (subject to § 2305);

2. Annual authority and trustee fees are allowed as paid or accrued (subject to § 2305);

3. Call premiums or penalties are allowable in the period(s) the holders of the refunded debt receive the principal payment. Call premiums or penalties of serial bonds should be prorated over the scheduled maturity or recall dates on the basis of the proportionate principal repayments at each date.

C. Unamortized discounts or premiums (reduction of debt cancellation costs) and debt issue costs of the refunded debt must be amortized over the period from the issue date of the refunding debt to the date the holders of the refunded debt will receive the principal payment (appropriately prorated in the case of serial bonds as in B. above).

D. Interest expense on the refunded debt is allowable on an annual basis as paid or accrued, whether by the provider or by a trust. (See § 2305ff.) Similarly, interest expense on the refunding debt is allowable as paid or accrued. The amortized portion of discounts or premiums on the refunding debt is an adjustment to allowable interest expense in accordance with §§ 212.1 or 214, respectively. The interest income derived from the investment of the proceeds of the refunding debt must be used to offset interest expense in accordance with § 202.2, whether this interest income is earned by the provider directly or through a trust.

The effect of the above treatment is to implicitly recognize any gain or loss incurred as the result of an advance refunding over the period from the date the refunding debt is issued to the date the holders of the refunded debt receive the principal payment, rather than immediately. The individual expense elements are the only costs which can be reimbursed in accordance with the above policy.

233.4 *Limitation on Recognition of Costs.* – As with all costs incurred for funds borrowed, the costs associated with an advance refunding must meet the necessary and proper tests of §§ 202.2 and 202.3, respectively, as well as the reasonable cost provisions of § 2100ff. In addition, sinking funds available for liquidation of the refunded debt must be considered in a determination of necessary

borrowing through advance refunding. On occasion a provider may borrow more than the amount required to advance refund the existing debt. If the additional borrowing is for the acquisition of depreciable assets, existing funded depreciation must be taken into account in determining the necessity of the excess borrowing. Generally, the total net aggregate allowable costs (as described in § 233.3) incurred for all cost reporting periods related to the advance refunding cannot exceed the total net aggregate costs that would have been allowable had the advance refunding not occurred. However, in evaluating the necessity, propriety and prudency of an advance refunding, consideration may be given to factors such as cash flow needs or the necessity to remove a restrictive covenant that prevents the provider from borrowing additional funds for an appropriate purpose.

If the provider incurs excess aggregate costs, as described above, the excess costs will be allowable only where the provider can demonstrate to the satisfaction of the intermediary that compelling factors (such as those mentioned above) necessitated the advance refunding. In cases where the provider cannot make such a satisfactory demonstration, the excess costs are unallowable, and the provider's reimbursement would be limited annually to the costs it would have incurred if the old bonds had not been refunded.

233.5 *Treatment of Items for Equity Capital Purposes.* – All debts, and proceeds of those debts, associated with advance refunding incurred for necessary patient care are includable in the determination of equity capital in accordance with Chapter 12. However, if interest expense is disallowed under the limitation expressed in § 233.4, the debt (or unreasonable portion thereof) associated with the disallowed interest expense, as well as the related assets, must be excluded in the determination of equity capital.

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No. 93-1907

In The

Supreme Court of the United States

October Term, 1994

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES,

Petitioner,

v.

MOTHER FRANCES HOSPITAL OF TYLER, TEXAS,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

BRIEF FOR THE RESPONDENT IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Are 42 C.F.R. §§ 413.20(a) and 413.24 properly used to determine timing of reimbursement of costs that are admittedly reimbursable by Medicare?

2. Is PRM § 233 invalid because it constitutes a substantive rule that was not promulgated in accordance with the Administrative Procedure Act?

3. Is the decision of the Administrator invalid because it is not supported by substantial evidence as required by 5 U.S.C. § 706 and 42 U.S.C. § 1395oo(d)?

LIST OF PARTIES

Pursuant to Supreme Court Rules 15, 24, and 29, Respondent states that the following persons are parties to this case:

(1) Mother Frances Hospital of Tyler, Texas;

(2) Donna E. Shalala, in her official capacity as Secretary of Health and Human Services; and

(3) Bruce C. Vladeck in his official capacity as Administrator of the Health Care Financing Administration.

Mother Frances Hospital has no parent company or subsidiaries other than wholly owned subsidiaries. The Medicare fiscal intermediaries for Mother Frances Hospital, Blue Cross and Blue Shield of Texas, Inc. and Blue Cross and Blue Shield Association, are not parties but are acting as agents for the Secretary and may have an interest in the outcome of this case.

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(b) Definitions – (1) Reasonable Cost. Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this part take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the cost with respect to individuals not so covered will not be borne by the program. These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services, from both Medicare and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services furnished to beneficiaries during the year.

. . .

5 U.S.C. § 706. Scope of review

. . . The reviewing court shall –

. . .

(2) hold unlawful and set aside agency action, findings, and conclusions found to be –

(A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;

. . .

(E) unsupported by substantial evidence in a case subject to sections 556 and

> 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute;
>
> . . .

In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party. . . .

STATEMENT OF THE CASE

On May 31, 1994, Petitioner Donna E. Shalala, Secretary of the Department of Health and Human Services (the "Secretary") filed a Petition for a Writ of Certiorari in this case. The Petition, after the Statement, contained no detailed arguments as to why the Petition should be granted. Instead, it referenced the case of *Shalala v. Guernsey Memorial Hospital*, in which a Petition for a Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit was granted on April 4, 1994. Under the heading "Reasons for Granting the Petition" Petitioner stated:

> This case presents the same questions that are presented in *Shalala v. Guernsey Memorial Hospital, cert. granted*, 114 S.Ct. 1395 (1994) (No. 93-1251). The petition should therefore be held and disposed of as appropriate in light of the Court's disposition of *Guernsey Memorial Hospital*.

M. Fr. Pet. at 12. On June 30, 1994, Respondent Mother Frances Hospital of Tyler, Texas (the "Hospital") filed and served a letter pursuant to S. Ct. Rule 15.4, waiving its right to file an opposition to the Petition. By letter dated July 15, 1994, the Clerk of this Court advised counsel for the Hospital that although the Hospital had waived its right to file a response to the Petition, the Court had nevertheless directed the Clerk to request that a response be filed.

I. Comparison Of Issues In This Case And *Guernsey*.

As will be explained more fully below, two out of the three questions presented by the instant case are identical to the two questions presented in *Guernsey*. Those questions are the GAAP question and the rulemaking question (Nos. 1 and 2 in Questions Presented, above). A third issue in this case, not listed by the Secretary as a "Question Presented" in the Mother Frances Petition, is whether the decision of the Administrator is supported by substantial evidence, as required by the Administrative Procedure Act ("APA") and the Medicare statutes. This issue was pleaded and briefed in the *Mother Frances* case in the District Court and the Court of Appeals, and it is properly presented in connection with the Petition in this case. The "substantial evidence" question is not listed as one of the "questions presented" in the *Guernsey* case, although Mother Frances Hospital believes it is necessarily presented in the *Guernsey* case as well.[1]

If either the GAAP or rulemaking arguments were to be decided in favor of the Respondent hospital in *Guernsey*, the outcome in that case would control the outcome of the instant case. An adverse decision to the hospital in

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[1] 42 U.S.C. § 1395oo(d) requires that a decision of the PRRB "*shall* be based upon the record made at such hearing," and "*shall* be supported by substantial evidence when the record is viewed as a whole." (emphasis added) Judicial review of agency decisions in this context is made "pursuant to the applicable provisions under Chapter 7 of title 5," which include 5 U.S.C. § 706. *See* 42 U.S.C. § 1395oo(f). As set forth above, 5 U.S.C. § 706(2)(E) provides that an agency decision must be reversed if it is "unsupported by substantial evidence in a case . . . reviewed on the record of an agency hearing provided by statute."

Counsel for Mother Frances Hospital is informed that the substantial evidence issue was pleaded and discussed in the briefs in the *Guernsey* case in the lower federal courts.

Guernsey on both the GAAP and rulemaking arguments would control the decision of those two issues in this case.[2]

It is legally possible that a different result could be reached on the substantial evidence issues in the two cases. The substantial evidence issue is expressly listed as a "Question Presented" in this case (see above), and there are differences in the administrative records between the two cases. *See* discussion in "Reasons for Denying the Writ," Part III, below. However, the Hospital believes that in both cases the Administrator's decisions are not supported by substantial evidence.

Because of the identical GAAP and rulemaking issues in the *Guernsey* case and the instant case, and because the Hospital believes that the decisions of the Administrator in both cases are not supported by substantial evidence, the Hospital initially determined to waive its right to file a response to the Petition.

In the Hospital's view, a different result could be reached in *Guernsey* and *Mother Frances* only under the following circumstances, assuming that the *Mother Frances* case is held in abeyance during the pendency of *Guernsey* as requested by the Secretary.

- First, the Court would have to decide adversely to the hospital both of the two issues expressly presented by *Guernsey*.
- Second, the Court would either not reach the substantial evidence question in *Guernsey*, or would decide it based on the *Guernsey* record.

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[2] Throughout this discussion, the Hospital assumes that the issues in *Guernsey* will be decided on their merits, as opposed to being decided on some procedural ground. The Hospital is unaware of any procedural ground that would prevent the issues expressly presented in *Guernsey* and *Mother Frances* from being decided on their merits.

- Third, the Court would remand *Mother Frances* to consider whether the decision of the Administrator was supported by substantial evidence in the record.
- Fourth, on remand the lower court would conclude that a decision favorable to the Hospital would be reached in *Mother Frances* because the substantial evidence argument, which had not been considered by this Court in *Guernsey*, would be considered and would cause the Hospital to prevail; or, if this Court had considered the substantial evidence argument in *Guernsey*, the lower court would render a different decision than was rendered in *Guernsey* on grounds that the administrative records in the two cases justified differing outcomes.

Although this scenario is possible, the chance that precisely this outcome would occur was considered insufficiently likely that the decision was made to waive a response to the Petition.

Because the Court has requested a response, however, the Hospital will respond to the contentions of the Secretary in the *Mother Frances* Petition and the *Guernsey* Petition. The contentions specific to Mother Frances Hospital are contained in the "Statement" portion of the *Mother Frances* Petition. Therefore, those contentions will be responded to in the Statement of the Case herein.

The legal arguments raised by the Secretary are set forth only in the "Reasons for Granting the Writ" in the *Guernsey* Petition. Those arguments will therefore be addressed in "Reasons for Denying the Writ" in this Opposition.

In summary, although the Hospital recognizes that the Court has granted the Petition in the *Guernsey* case, the Hospital believes that certiorari should not be granted in the *Mother Frances* case. With the benefit of hindsight, having participated as an *amicus curiae* in the briefing in the *Guernsey* case, the Hospital also respectfully suggests

that certiorari may have been improvidently granted in *Guernsey*.

II. Disagreements With The "Statement" In The Petition.

The Hospital disagrees with several contentions by the Secretary in the "Statement" portion of the *Mother Frances* Petition. The Secretary states that the Medicare Act "authorizes the Secretary of Health and Human Services to promulgate regulations 'establishing the method or methods to be used'" for determining reasonable costs. M. Fr. Pet. at 5. The Medicare Act does not merely "authorize" the Secretary to issue regulations establishing such methods. The Act commands her to do so. The pertinent portion of 42 U.S.C. § 1395x(v)(1)(A) states:

> The *reasonable cost* of any services shall be the cost actually incurred . . . and *shall be determined in accordance with regulations establishing the method or methods to be used. . . . In prescribing the regulations* referred to in the preceding sentence, *the Secretary shall consider*, among other things, the principles generally applied by national organizations . . . in computing the amount of payment . . . to providers of services. . . . *Such regulations* may provide for [determination of costs according to different methods]. (emphasis added)

42 U.S.C. § 1395hh also imposes an obligation upon the Secretary to proceed by rulemaking in certain instances.[3] *See also* 42 C.F.R. § 413.9(b)(1) ("Reasonable cost of any services *must* be determined in accordance with *regulations* establishing the method or methods to be used . . . . "). (emphasis added)

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[3] 42 U.S.C. § 1395hh was amended after PRM § 233 was issued. *See* discussion in Amicus Br. of M. Fr. Hosp. at 7 n.2.

It is not true, as the Secretary states in her description of the 1983 bonds, that those bonds "bore interest at rates ranging from 8.6% to 9.5%, and were scheduled to reach maturity in 1998." M. Fr. Pet. at 6. $7,190,000 in serial bonds were due by 1998 at the interest rates cited by the Secretary. Admin. Rec. 1114. However, most of the bonds were term bonds. $19,365,000 in term bonds bore a rate of 9 3/4% and were due in the year 2007, and $25,780,000 in term bonds bore a rate of 10 1/8% and were due in 2013. *Id.*

Although the hospital estimated it would save $2,714,975 under the new bonds as compared to the old bonds, that estimate has little if any relevance to this case. M. Fr. Pet. at 7. The Secretary has consistently sought to imply that the Hospital would gain by a reduction in interest expense, and at the same time receive a windfall from Medicare for an "accounting loss" or "paper loss." *See* M. Fr. Pet. at 7 ("accounting loss"); Appellee's 5th Cir. Br. at 2 ("paper loss"). The Hospital's annual interest expense would be lower after the refinancing due to lower interest rates, but Medicare would share fully, dollar for dollar, in those savings because Medicare would reimburse the hospital based on those lower interest payments. The loss on defeasance, however, was a loss incurred in fiscal year 1987 to defease or extinguish its liability on the old bonds. The uncontradicted record testimony was that this was not a paper loss, but a real loss. Admin. Rec. 453-54, 457 (Valorz).[4]

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[4] The Secretary apparently seeks to create some confusion regarding the amount of the loss. M. Fr. Pet. at 8. There should be no doubt about this issue. The PRRB's decision did not determine the size of the loss, even though the Hospital submitted figures showing the dollar amount of the loss ($11,671,393) and the estimated reimbursement impact ($4,565,362). Admin. Rec. 1012. The loss figure was taken from

REASONS FOR DENYING THE PETITION

I. There Is No Conflict Among The Circuits On The GAAP Question.

The arguments advanced in the *Guernsey* Petition for granting certiorari are seriously flawed. Mother Frances Hospital therefore believes that certiorari should not be granted in the instant case, and respectfully suggests that the Petition in *Guernsey* may have been improvidently granted based upon allegations of a conflict among the circuits when such a conflict simply does not exist.

Both *Guernsey* and *Mother Frances* are "advance refunding" or "loss on defeasance" cases. The ultimate issue in each case is whether a loss on defeasance of debt should be reimbursed by Medicare in the year in which the defeasance occurred or whether it should be amortized over a future period of years.

All extant Court of Appeals decisions and District Court decisions in these "loss on defeasance" cases are in complete accord and have reached the identical result. The case law is unanimous. In every case presenting this ultimate issue, the courts have held that the provider is entitled under applicable Medicare statutes and regulations to receive reimbursement in the year of defeasance. There is not even arguably any conflict among circuits, or

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the Intermediary's own workpaper furnished by the Intermediary to the Hospital. In the District Court, counsel for the Secretary refused to admit the validity of the size of the loss calculated by the Intermediary, shown on the Intermediary's own workpaper, and given to the Hospital. In any event, the size of the loss and the reimbursement impact can be calculated on remand should the Hospital prevail, as the Fifth Circuit directed. M. Fr. Pet. at 10a.

among district courts, as to the proper result in these cases. These cases are:

Courts of Appeals

Guernsey Memorial Hosp. v. Secretary of HHS, 996 F.2d 830 (6th Cir. 1993), *cert. granted*, 114 S. Ct. 1395 (1994); *Mother Frances Hosp. of Tyler, Texas v. Shalala*, 15 F.3d 423 (5th Cir. 1994), *petition for cert. filed* (May 31, 1994).

District Courts

Methodist-Evangelical Hosp., Inc. v. Shalala, Medicare & Medicaid Guide (CCH) ¶ 42,017 (D.D.C. Dec. 22, 1993); *St. John's Hosp. v. Shalala*, Medicare & Medicaid Guide (CCH) ¶ 41,700 (E.D. Mich. Aug. 18, 1993); *Graham Hosp. Ass'n v. Sullivan*, 832 F. Supp. 1235 (C.D. Ill. 1993); *Mercy Hosp. v. Sullivan*, Medicare & Medicaid Guide (CCH) ¶ 40,227 (D. Me. 1991); *Baptist Hosp. East v. Sullivan*, 767 F. Supp. 139 (W.D. Ky. 1991); *Ravenswood Hosp. Medical Center v. Schweiker*, 622 F. Supp. 338 (N.D. Ill. 1985).

To attempt to create a conflict where none exists, the Secretary has endeavored to recast the issue in extremely broad terms, and to bring in other cases that are not "loss on defeasance" cases but have presented other issues under some of the same regulations involved in this case. Thus, she characterizes the question as "whether the Secretary and fiscal intermediaries are required to follow GAAP," Guern. Pet. at 11, and "[w]hether [the regulations] require that provider costs be reimbursed according to 'generally accepted accounting principles . . . .'". M. Fr. Pet. at I.

But the Courts of Appeals and District Courts have not painted with such a broad brush. Even if it were necessary or appropriate for this Court to grant certiorari to consider an alleged conflict that is not present in the line of cases of which this case is a part, the decisions

cited by the Secretary in the *Guernsey* Petition do not conflict with each other. They can be reconciled by using precisely the analysis employed by the Fifth Circuit Court of Appeals in the *Mother Frances* case; namely, that §§ 413.20(a) and 413.24 are not necessarily used to determine which costs are "allowable" for Medicare reimbursement but are properly used to determine accounting issues, such as timing, for costs that are "allowable."

The Secretary lists the following ten cases as standing for the proposition that 42 C.F.R. §§ 413.20 and 413.24 "mandate the use of GAAP to determine allowable costs, unless the Secretary has promulgated a more specific regulation dealing with a particular cost issue" (Guern. Pet. at 11):[5]

Courts of Appeals

Guernsey Memorial Hosp. v. Secretary of HHS, 996 F.2d 830 (6th Cir. 1993), *cert. granted*, 114 S. Ct. 1395 (1994); *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179 (9th Cir. 1989); *Charlotte Memorial Hosp. & Medical Center, Inc. v. Bowen*, 860 F.2d 595 (4th Cir. 1988); *National Medical Enterprises v. Bowen*, 851 F.2d 291 (9th Cir. 1988); *Villa View Community Hosp., Inc. v. Heckler*, 720 F.2d 1086 (9th Cir. 1983).

District Courts[6]

Methodist-Evangelical Hosp., Inc. v. Shalala, Medicare & Medicaid Guide (CCH) ¶ 42,017 (D.D.C. Dec. 22, 1993); *Graham Hosp. Ass'n v. Sullivan*, 832 F. Supp. 1235 (C.D. Ill.

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[5] The Secretary did not include the *Mother Frances* case, because the decision in that case was rendered by the Fifth Circuit after the Petition in *Guernsey* was filed. Presumably, she would align it with *Guernsey*.

[6] The Secretary omits *St. John's Hosp. v. Shalala*, Medicare & Medicaid Guide (CCH) ¶ 41,700 (E.D. Mich. Aug. 18, 1993).

1993); *Mercy Hosp. v. Sullivan*, Medicare & Medicaid Guide (CCH) ¶ 40,227 (D. Me. 1991); *Baptist Hosp. East v. Sullivan*, 767 F. Supp. 139 (W.D. Ky. 1991); *Ravenswood Hosp. Medical Ctr. v. Schweiker*, 622 F. Supp. 338 (N.D. Ill. 1985).

The only cases which allegedly establish a different rule, according to the Secretary, are as follows:[7]

Courts of Appeals

Sun Towers, Inc. v. Heckler, 725 F.2d 315 (5th Cir.), *cert. denied*, 469 U.S. 823 (1984); *National Medical Enterprises v. Sullivan*, 916 F.2d 542 (9th Cir. 1990), *cert. denied*, 500 U.S. 917 (1991); *North Clackamas Community Hosp. v. Harris*, 664 F.2d 701 (9th Cir. 1980).

District Courts

American Medical Int'l, Inc. v. Secretary of HEW, 466 F. Supp. 605 (D.D.C. 1979), *aff'd*, 677 F.2d 118 (D.C. Cir. 1981); *Queen's Medical Center v. Sullivan*, 797 F. Supp. 821 (D. Haw. 1991).

Court of Claims

Methodist Hospital of Indiana, Inc. v. United States, 626 F.2d 823 (Ct. Cl. 1980).

None of these cases establishes a rule that differs from that applied in *Mother Frances* or *Guernsey*.

To see why this is so, the law in the Fifth Circuit is the most instructive. The principal case cited by the Secretary to show a supposed conflict is *Sun Towers*, which quoted from and relied upon *American Medical* in its holding. What the Secretary's argument overlooks, however, is that the "stock

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[7] The Secretary also cites *Richey Manor, Inc. v. Schweiker*, 684 F.2d 130 (D.C. Cir. 1982), but notes that any such expression of a different rule was dictum.

maintenance" cost cases, such as *Sun Towers* and *American Medical*, have to do with whether § 413.20(a) is to be used to determine "costs *allowable*" under the Medicare program; that is, "*reimbursable* costs." *Sun Towers*, 725 F.2d at 329, *citing American Medical*, 466 F. Supp. at 623. (emphasis added) "Allowable costs" is a term of art, and means whether the costs are of the kind for which Medicare will reimburse providers. To be allowable, costs must be related to patient care. 42 C.F.R. § 413.9(c)(3). In *Sun Towers*, the Court noted that the Secretary had found that "these costs were not related to actual patient care or necessary to the rendition of patient care services. Therefore, she concluded, these costs could not properly [be reimbursed]." *Sun Towers*, 725 F.2d at 326.

But the *Mother Frances* and *Guernsey* cases are not about whether the loss on defeasance is an "allowable," reimbursable cost under Medicare. The loss is admittedly a reimbursable cost.[8]

Instead, the question presented by loss on defeasance cases such as *Mother Frances* and *Guernsey* is simply an accounting question: in what year should the admittedly allowable cost be recognized? It is solely a question of timing.

After noting that *Sun Towers* is not contrary to its decision in *Mother Frances*, the Fifth Circuit explained exactly why there is no conflict:

> In *Sun Towers*, this Court was called on to decide whether certain costs were allowable under the Medicare program. Among these costs were

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[8] The Secretary explicitly so stated in her summary judgment brief filed in the District Court in this case: "There is no dispute that the 'loss' represents costs which are reimbursable under the Medicare program. Instead the dispute concerns the time period over which the hospital may be reimbursed for this loss." Def. Summ. J. Br. at 7.

"stock maintenance costs." The Secretary disallowed reimbursement for these costs finding that they were only tangentially related to the care of Medicare beneficiaries. The district court, however, reversed the Secretary's determination.

Among the arguments the district court presented to support its decision in *Sun Towers* was an argument based on GAAP. Under GAAP, stock maintenance costs are recognized as general and administrative expenses. Thus, the district court argued that these costs were allowable because 42 C.F.R. § 405.406 [the predecessor to § 413.20] required GAAP to be applied in determining reasonable costs.

We rejected this argument holding that GAAP was not necessarily to be used in determining if a particular cost was allowable. In particular, we found that section 405.406 was not designed to determine the *"costs allowable* under the Medicare Act. The regulation is directed at the type of financial data and reports required of providers; it is not a regulation affecting the substantive provisions of the program as to *what constitutes reimbursable costs."* Hence, we reversed the decision of the district court and held that the Secretary's determination was neither arbitrary nor capricious.

In *Sun Towers,* the issue was *whether* a particular cost was allowable at all. In the case at bar, as it was in the *Guernsey* case, the issue is *when* a cost that was clearly allowable should have been reimbursed. These are different questions and we do not believe that *Sun Towers* speaks to the issue of *when* reimbursement is to be made.

> Accordingly, we adhere to our decision in *Sun Towers* as to *whether* a particular cost is allowable. However, we follow *Guernsey* as to *when* advance refunding costs are to be reimbursed.

M. Fr. Pet. at 9a-10a (all footnotes and citations omitted; emphasis by Fifth Circuit). The Fifth Circuit further stated in *Mother Frances* that *Guernsey* is "a case on all fours with the case *sub judice*," and that "[w]e agree with the reasoning of *Guernsey* and adopt its holding that the Medicare regulations provide for the use of GAAP in determining the timing of Medicare reimbursement in advance refunding transactions. . . . " M. Fr. Pet. at 8a.

There can thus be no conceivable conflict between *Sun Towers* and either *Guernsey* or *Mother Frances*, when the Fifth Circuit expressly reconciled its decision in *Sun Towers* with its decision in *Mother Frances* and with the *Guernsey* case.

The Secretary cites a District Court case from the District of Columbia, *American Medical*, as presenting a conflict. But *American Medical* was also distinguished by the District Court that decided it as presenting no conflict with the line of decisions in advance refunding cases. In *Methodist-Evangelical*, the United States District Court for the District of Columbia considered two consolidated advance refunding cases that had been brought by a total of seven hospitals. That court noted that the "issues here have been thoroughly and authoritatively resolved in the Sixth Circuit's opinion in *Guernsey*." *Methodist-Evangelical*, Medicare & Medicaid Guide (CCH) ¶ 42,017 at 38,788. It expressly distinguished *American Medical* (and *Richey Manor*) on grounds that "each of these cases determines reimbursability *vel non*; none addresses the timing of reimbursement. *Guernsey* teaches that GAAP governs reimbursement timing and is what is at issue here. The law of this Circuit does not compel an interpretation different from that in *Guernsey*." *Id.* at 38,789.

Turning to the Ninth Circuit, the principal case that the Secretary believes to have established a rule contrary to *Guernsey* and *Mother Frances* is *NME v. Sullivan*. But that case, too, like *Sun Towers* and *American Medical*, is a "stock maintenance" costs case. It is distinguishable on precisely the same basis that the Fifth Circuit and the District Court for the District of Columbia distinguished *Sun Towers* and *American Medical*.

The only other Ninth Circuit case cited by the Secretary as being in conflict with *Guernsey* and *Sun Towers* is *North Clackamas*. That case also dealt with whether certain costs were related to patient care, and thus whether they were "allowable," reimbursable costs. The issue in *North Clackamas* was whether certain intangible costs were reimbursable. The Court, per Kennedy, J., held that the costs were "not reimbursable." 664 F.2d at 707. *North Clackamas* is thus like *Sun Towers*, *American Medical*, and *NME v. Sullivan*, because the issue in that case was whether costs were "allowable" rather than how admittedly allowable costs ought to be treated under applicable accounting rules.[9]

This leaves only *Methodist Hospital of Indiana* as a case supposedly in conflict with *Guernsey* and *Mother Frances*. That case does not present a conflict for several reasons.

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[9] The Secretary also cites *Queens* as establishing a rule contrary to *Guernsey* and *Mother Frances*. Guern. Pet. at 13 n.8. But *Queens* is only a District Court case within the Ninth Circuit. As shown above, there is no conflict between the two Ninth Circuit cases cited by the Secretary, and *Guernsey* and *Mother Frances*. In addition, the question in *Queens* was whether certain malpractice costs were reimbursable at all. The Court noted that GAAP was not designed "for determining what health care costs are reasonable and should be *reimbursable* under Medicare." *Queens*, 797 F. Supp. at 826. Thus, its holding also does not conflict with *Mother Frances*.

- First, it does not even involve the application of § 413.20(a), the GAAP regulation. It deals only with accrual accounting issues.
- Second, like the cases cited above, the question in *Methodist Hospital of Indiana* was whether a cost was reimbursable at all. The Court held that a cost that was legally required to be paid but was not paid, could be determined not to have been "incurred" and thus not be reimbursable. *Methodist Hospital of Indiana*, 626 F.2d at 827.
- Third, the Court of Claims in this 1980 decision had jurisdiction only because the statutory procedure which established the PRRB and the present administrative and judicial mechanisms for review of provider disputes was not yet in effect for the cost year at issue. The mechanisms established by 42 U.S.C. § 1395oo are effective only for provider cost reports ending on or after June 30, 1973. *See* Pub. L. 92-603, § 243, 1972 U.S.Code Cong. & Admin. News (92 Stat.) 1661-63. The dispute in *Methodist Hospital of Indiana* was for the hospital's fiscal year ended February 28, 1969. Jurisdiction for judicial review of PRRB and Administrator's decisions is now vested exclusively in the federal District Courts, not the Court of Federal Claims. 42 U.S.C. § 1395oo(f). Thus, even if *Methodist Hospital of Indiana* established some rule that was in conflict with *Guernsey* and *Mother Frances* – which it did not – any such conflict would be essentially irrelevant at present.

Thus, to attempt to show a conflict, the Secretary has stated the "question presented" in an overly broad manner.[10] The advance refunding cases are unanimous. But even when

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[10] The "question presented" is also phrased in a circular fashion by the Secretary. By describing §§ 413.20(a) and 413.24 as "general Medicare record-keeping and reporting regulations" the Secretary has attempted to insert her answer to the question into the question itself.

the broader question is examined, the cases are reconcilable on the basis expressed in *Mother Frances.*

The Petition should also be denied because the Secretary is now arguing in this Court a considerably different case than was argued below. Her arguments contradict the positions that she has taken in prior stages of this case and elsewhere.

For example, a question considered in the proceedings below was whether § 413.20(a) deals with reimbursement under GAAP because it was meant to implement the language of 42 U.S.C. § 1395x(v)(1)(A). That statute requires that "In prescribing the regulations [to determine reasonable costs], the Secretary shall consider . . . the principles applied by national organizations or established prepayment organizations . . . in computing the amount of payment . . . to providers of services . . . . "

At page 21 of the *Guernsey* brief on the merits, the Secretary now argues that "[t]he available evidence thus confirms what is in any event the natural reading of the statutory language: that the 'principles . . . applied by national organizations or established prepayment organizations' that the statute requires the Secretary to 'consider' have nothing specifically to do with GAAP." However, that position directly contradicts the Secretary's administrative decision in this case. In a discussion of GAAP principles, the following statement appears in the Administrator's decision:

> Section 1861(v)(1)(A) of the Act only required the secretary to "consider . . . the principles generally applied by national organizations." The Secretary is not required to adopt them for determining reimbursable costs. [*citing* three cases, including *Sun Towers* and *American Medical*]. Neither Congress nor the Secretary abdicated to the accounting profession the responsibility for determining Medicare reimbursement policy. Moreover, the Foreword to the PRM indicates that GAAP should be

> followed only in the absence of specific guidelines and instructions in the PRM. [footnote omitted]

M. Fr. Pet. at 50a. As is evident from this passage in the *decision under review in this case*, the Secretary entertained no doubt that the statutory language relating to "principles generally applied by national organizations" referred to GAAP. Now, the Secretary urges this Court to adopt the opposite position on a fundamental issue expressly treated in the Administrator's decision.

Similarly, the Secretary seeks to argue a different case in this Court than it did in the lower courts with respect to the effect of 42 U.S.C. § 413.20(a). Below, the Secretary merely sought to argue that § 413.20(a) is not a payment or reimbursement provision, but relates to recordkeeping only. Now, in this Court, the Secretary argues in the *Guernsey* case that § 413.20(a) does not even *refer* to GAAP or relate to GAAP in any way:

> In any event, Section 413.20(a) by its terms does not require use of GAAP. It refers only to practices standard "in the hospital and related fields," suggesting if anything the use of "specially" rather than "generally" accepted principles.

Guern. Pet. at 19. In both the Court of Appeals and the District Court in this case, the Secretary explicitly admitted and argued that § 413.20(a) referred to GAAP (although contending that it did not govern payment or reimbursement). In the Fifth Circuit, the Secretary argued that the language of § 413.20:

> [I]nforms providers that they need not "change" their "standard accounting practices" in order to participate in the Medicare program. It does *not* direct that all costs found by such "standard practices" will be reimbursed. Such an approach would improperly transfer the authority to determine what costs are reimbursable under Medicare from the Secretary to the American Institute of Certified

> Public Accountants ("AICPA"), which promulgates GAAP. (emphasis in original)

Appellees' 5th Cir. Br. at 20. The Secretary stated in that same brief, at 21, that by the provisions of § 413.20(a) "the Secretary did not mandate that a provider's 'standard practices' in keeping its accounting books and records (which is, after all, what GAAP is) should govern the amount of reimbursement payable under the program."

In other cases, contrary to the position argued by the Secretary below, the Secretary has taken the position that the GAAP provisions of § 413.20(a) require *reimbursement* (not mere recordkeeping) in accordance with GAAP. *See* cases cited in Amicus Br. of AHA at 14-16.

Thus, the Hospital believes that it is unnecessary and inappropriate to grant certiorari in this case to afford the Secretary the opportunity to establish legal propositions that are directly contrary to positions she has adopted in other cases, and, indeed, in this very case.

II. The Rulemaking Question Furnishes No Basis For Granting Certiorari.

The Secretary does not claim in the Guernsey Petition that there is any conflict among the circuits on the rulemaking issue. Indeed, all courts that have considered the rulemaking issue in this context have held that PRM § 233 is invalid as a substantive rule. There is no asserted conflict as to the legal standard to be applied on this issue. Thus, the rulemaking question presents no special reason for granting the petition in either the *Mother Frances* or *Guernsey* cases.

It is important to clarify the relationship of the GAAP argument to the rulemaking argument. The Secretary claims that the Court's conclusion that § 233 is an invalid substantive rule would have "no force independent of the court's determination that the Manual provision . . . conflicts with a GAAP accounting requirement embodied in

Sections 413.20 and 413.24 of the regulations . . . . " Guern. Pet. at 22. Mother Frances Hospital expressly argued before the Fifth Circuit that the "rulemaking arguments urged throughout this brief are logically independent of the GAAP and accrual accounting arguments" set forth therein. Appellant's 5th Cir. Br. at 27. The brief continued: "If it is true that 42 C.F.R. § 413.20 requires GAAP to be followed in determining reimbursement, as the *Guernsey* court held and as argued below, PRM § 233 unquestionably represents a change from that regulatory requirement. But even if 42 C.F.R. § 413.20 did not require GAAP to be followed, PRM § 233 is still a substantive rule . . . . " *Id.*

This rulemaking argument was set forth explicitly as Count II of the Complaint, and was briefed as an independent argument in the District Court and the Fifth Circuit. Pl. Summ. J. Br. at 26-33; Appellant's 5th Cir. Br. at 19-31.

There is an important shift between the Secretary's position in the Guernsey Petition, and in the brief on the merits submitted by the Secretary in that case. In the Guernsey Petition, the cited case law discussed only the definitions of "substantive" as opposed to "interpretative" rules. Guern. Pet. at 23. The Secretary then argued that "Section 233 of the PRM is plainly an interpretative rule." *Id.* Although the Petition mentioned that "statements of policy" could be exempted from APA notice and comment requirements, *id.*, the Secretary did not argue that § 233 constituted a "general statement of policy." In the Secretary's brief on the merits, however, she now argues that PRM § 233 is a "general statement of policy." Guern. Pet. Br. at 35.

The argument that § 233 is a "general statement of policy" was never advanced by the Administrator in his decision, by the Secretary in the District Court in *Mother Frances*, or by the Secretary in the Fifth Circuit. Counsel for Mother Frances is informed that it was not argued in the Sixth Circuit in *Guernsey*. It is a new argument, advanced for

the first time in this Court, after the Petition was granted. Case law demonstrating that PRM § 233 cannot be considered a "general statement of policy" is contained in the Mother Frances Amicus Brief at 19.

The Secretary contends that certiorari should be granted in this case because "an agency's interpretation of its own regulations should be given 'controlling weight' unless it is plainly erroneous or inconsistent with the language of the regulation." Guern. Pet. at 26. She complains of "judicial misinterpretation" of her regulations. *Id.*

As is clear from the history of the *Mother Frances* case, however, the Secretary has been at a loss even to identify the regulations of which PRM § 233 is allegedly interpretative.

The Administrator's decision identified only one regulation of which PRM § 233 was supposedly interpretative. That regulation is 42 C.F.R. § 413.9(b)(1). The Administrator's decision asserts that § 233 "is interpretative of 42 C.F.R. 413.9" which, according to the Administrator, "requires payments to be based on 'the actual cost of services rendered to beneficiaries during the year.'" M. Fr. Pet. at 49a.[11] As shown at length in the Mother Frances Amicus Brief at 12-15, § 413.9(b)(1) has nothing to do with the issues in this case. The argument by the Administrator depends entirely upon quoting a small portion of that regulation out of context. The regulation does not pertain to attribution of costs to particular years. Instead, § 413.9(b)(1) deals with retroactive adjustments, which are used simply to reconcile the final cost amount shown in the Medicare cost report to the amounts paid on an interim basis during the year.

In the District Court, the Secretary specifically claimed, at several places in her brief, that PRM § 233 was interpretative of § 413.9(b)(1). For example, the Secretary argued that

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[11] The Administrator cites the regulation as 42 C.F.R. § 413.9, but the portion quoted is from § 413.9(b)(1).

" . . . PRM § 233 is interpretive of defendant's policy that a Medicare provider will be reimbursed only for the actual cost of providing services to beneficiaries during the year as required by 42 C.F.R. § 413.9(b)(1)." Def. Summ. J. Br. at 28-29.[12]

In the Fifth Circuit Court of Appeals, the Hospital in its opening brief demonstrated that § 413.9(b)(1) has nothing to do with apportionment of costs *among years*, by an argument similar to that set out in the Mother Frances Amicus Brief at 12-15. The Secretary responded by listing a series of five *different* regulations of which PRM § 233 is allegedly interpretative, while § 413.9(b)(1) disappeared from that list. *See* Appellees' 5th Cir. Br. at 38. Those regulations were:

- 42 C.F.R. § 413.5(b)(6)
- 42 C.F.R. § 413.9(b)(2) with a "see generally" citation to "Subpart G."
- 42 C.F.R. § 413.130(a)(10)
- 42 C.F.R. § 413.153(a)(1) and (b)(1)
- 42 C.F.R. §§ 413.5(a) and 413.9[13]

In the Fifth Circuit, the Hospital pointed out that 42 C.F.R. § 413.130(a)(10) was not promulgated until more than

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[12] *See also id.* at 2 (" . . . PRM § 233 properly interprets the regulation requiring that a provider be reimbursed only for the actual cost of health care services furnished to Medicare beneficiaries during the year. *See* 42 C.F.R. § 413.9(b)(1)"); *id.* at 5 ("Medicare payments in a given cost year must be based on the 'actual cost *of services* furnished to beneficiaries *during the year*.' 42 C.F.R. § 413.9(b)(1)." (emphasis in Def. Br.))

[13] 42 C.F.R. §§ 413.5(a) and 413.9 were cited for the proposition that "regulations require that reimbursable costs be related to Medicare patient care." Appellees' 5th Cir. Br. at 38. The subsection of 413.9 that stands for that proposition is 42 C.F.R. § 413.9(c)(3), which confirms that "amounts not related to patient care" are not "allowable," that is, are not reimbursable costs.

eight years after PRM § 233 became effective. *See* Amicus Br. of M. Fr. Hosp. at 16. In this Court, the Secretary now cites a group of regulations similar to those relied upon in the Fifth Circuit, although 42 C.F.R. § 413.130(a)(10) has been dropped, and two different regulations (42 C.F.R. §§ 413.130(a)(7) and (g)) have been added. 42 C.F.R. § 413.5(b)(6) was dropped as well. A reference to the Administrator's reliance on 413.9(b)(1) has also reappeared. Pet. Br. at 39.

Arguments showing that PRM § 233 is not interpretative of any of these regulations were set forth at pages 12-19 of the Amicus Brief of Mother Frances Hospital, and will not be repeated here. The two newly added regulations, however, deserve special mention. In addition to arguing that §§ 413.130(a)(7) and (g) add nothing to the analysis in this case, Mother Frances pointed out that those two subsections were *also* published after PRM § 233 was issued. Amicus Br. of M. Fr. Hosp. at 16. Sections 413.130(a)(7) and (g) were not published as an interim final rule until September 1, 1983. *See* 48 Fed. Reg. 39752, 39809, 39810 (Sept. 1, 1983). This was approximately four months after the issuance of PRM § 233, and two months after its effective date. *See* Amicus Br. of M. Fr. Hosp. at 16-17.

In her reply brief in the *Guernsey* case, the Secretary responded that the September 1, 1983 *Federal Register* notice publishing 42 C.F.R. §§ 413.130(a)(7) and (g) "merely reorganized and clarified the preexisting regulations that had authorized reimbursement of capital-related costs, such as interest and 'other costs related to . . . capital expenditures.' *See* 42 C.F.R. 405.402(c), 405.419, 405.435 (1982)."[14] Guern. Pet. Reply Br. at 9 n.5.

The September 1, 1983, *Federal Register* notice did nothing of the kind.

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[14] At the time of publication of the notice, what is now 42 C.F.R. § 413.130 was originally codified as 42 C.F.R. § 405.414.

Section 405.419, designated as "Interest expense," is merely the predecessor to § 413.153, the current interest regulation. The September 1, 1983 *Federal Register* notice did not amend, change, or reorganize § 405.419 in any fashion.

Section 405.435, captioned "Nonallowable costs related to certain capital expenditures," related to state capital expenditure review activities under Section 1122 of the Social Security Act. Section 1122 created a voluntary capital expenditure review program in which states could participate, and is not relevant to the issues in this appeal. This section was not changed or amended by the September 1 *Federal Register* notice.

Section 405.402(c) was misquoted by the Secretary. She contends in her Reply Brief that § 405.402(c) authorized reimbursement for "other costs related to . . . capital expenditures." Guern. Pet. Reply Br. at 9 n.5. However, the relevant text of 405.402(c), after discussing certain items under the principles of reimbursement, stated as follows:

> However, costs such as depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary providers), and other costs related to certain capital expenditures are subject to the provisions of § 405.435, "Nonallowable costs related to certain capital expenditures."

In other words, § 405.402(c) did not "authorize reimbursement" of capital expenditures as the Secretary asserts, but merely noted that certain capital expenditures were subject to the Section 1122 state review program as referenced in § 405.435, discussed above.

Plainly, the September 1, 1983, *Federal Register* notice did not "reorganize" or "clarify" any of these regulations. That fact can be easily ascertained by examining the text of § 405.414 in the September 1, 1983 notice, beginning at 48 Fed. Reg. 39809. Similarly, a comparison of the 1982 and 1983 editions of the Code of Federal Regulations reveals that all

three regulations cited by the Secretary as being "reorganized or clarified" by § 405.414 were unaffected by that new regulation.

The Secretary's complaints about the alleged "disregard" by the Court of Appeals of her interpretation of her own regulations, Guern. Pet. at 26, are seriously undermined by her shifts in position as to which regulations § 233 allegedly interprets, and her continued miscitation of regulations that were not even in effect at the time § 233 was issued.

III. The Substantial Evidence Question Does Not Justify Granting The Petition.

Because the Secretary did not include a "substantial evidence" issue in the "Questions Presented" in this case, there would appear to be no reason to grant certiorari based on that issue.

As noted above, the Hospital has presented a "substantial evidence" challenge to the decision of the Administrator throughout this lawsuit.[15] Count I of the Hospital's Complaint stated that "The Decision and the findings and conclusions therein are unlawful and should be set aside pursuant to 5 U.S.C. § 706 because they are arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law; are [in violation of other APA provisions]; and are unsupported by substantial evidence."

The substantial evidence argument was presented to the District Court in the Hospital's brief. *See* Pl. Summ. J. Br. at

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[15] Mother Frances Hospital is not attempting to distance itself from the *Guernsey* case by outlining the substantial evidence issue. The Hospital believes that in neither case is the Administrator's decision supported by substantial evidence. The evidence has been summarized here briefly to acquaint the Court with this issue for purposes of making an accurate procedural disposition of the case.

13 (citing substantial evidence test and cases); and 22-26 (discussing and citing testimony in the record). It was also explicitly briefed in the Fifth Circuit, as Issue No. 3 in the "Statement of the Issues". Appellant's 5th Cir. Br. at 3. This issue was not discussed by the Fifth Circuit in its opinion, presumably because the resolution of the first two issues (the GAAP and the rulemaking issues) in favor of Mother Frances Hospital made consideration of the substantial evidence issue unnecessary.

The record in the Mother Frances case consisted of stipulated testimony by four witnesses from three other cases. The three cases were *Guernsey*, *St. John's*, and *Mercy*. The testimony of expert witness Douglas Langenfeld on behalf of the provider in *Guernsey* was included in the record in Mother Frances, and is, of course, part of the record in *Guernsey*. Expert testimony on behalf of the provider in *St. John's* and *Mercy*, by John Valorz and Chris Corrie, also was stipulated as part of the *Mother Frances* record. Stipulated testimony on behalf of the intermediary was provided by Wilson Leong, from the *St. John's* case.

Some of the "substantial evidence" in the *Guernsey* case was set forth in the amicus brief filed by Mother Frances Hospital in that case. Amicus Br. of M. Fr. Hosp. at 26-28. This evidence is pertinent to the Administrator's finding that the loss on defeasance in "economic reality" relates to future years after the defeasance. The evidence in the *Mother Frances* record included the following:

- No cost is incurred by the provider in periods after the refunding. Admin. Rec. 467-68 (Valorz); 679, 705 (Leong).
- "There is no future interest cost to the provider" after defeasance. Admin. Rec. 703 (Leong).
- The loss on defeasance does not relate to any future period. Admin. Rec. 559-60, 578 (Langenfeld).
- No future costs related to the defeasance are reflected on the provider's books, such costs are not a liability of the

provider, and interest costs are not being incurred on the old debt by the provider in future years. Admin. Rec. 703, 705 (Leong).

- Providers are no longer liable for repayment of the old debt after an advance refunding transaction. Admin. Rec. 467, 473 (Valorz); 506-07, 516 (Langenfeld); 595-96 (Corrie); 690 (Leong).
- The provider no longer makes any payment relating to the refunded debt after the defeasance. Admin. Rec. 669 (Leong).
- The old debt ceases to exist for hospital purposes following a refunding. Admin. Rec. 506, 514 (Langenfeld).
- If the loss on defeasance is related to any year other than the year in which it was incurred, the loss relates to past periods and not future periods. Admin. Rec. 504 (Langenfeld); 603-04 (Corrie).
- The loss on advance refunding is a belated recognition of past costs upon extinguishment of the old bonds, specifically, the difference between the net carrying cost of the old bonds and the price necessary to reacquire the bonds. Admin. Rec. 499, 505, 510-11 (Langenfeld); 603-04, 611 (Corrie).
- Mr. Leong, the Intermediary's own witness, testified that he would look to GAAP [rather than 42 C.F.R. § 413.153, the interest regulation] in considering the timing of reimbursement. Admin. Rec. 663 (Leong).
- After contending that "the actuality of the situation is the debt has not been liquidated," Mr. Leong admitted that there is no basis in regulation for this assertion. Admin. Rec. 672 (Leong).

This testimony thus served to show that the "economic reality" argument – in which the loss on defeasance is said to relate to future years – had absolutely no basis in the administrative record. Similarly, the "cross-subsidization" argument advanced by the Administrator depends upon a finding that costs are attributable "in economic reality" to

future years, M. Fr. Pet. at 49a, 54a, a proposition that is overwhelmingly refuted by the administrative record.

In the *Guernsey* appeal, the Secretary admits that the issue of the periods to which the loss on defeasance relates is a factual matter. *See* Guernsey Br. at 16 ("[t]he Secretary's conclusion that the costs at issue here must be apportioned over several periods is entirely justified, both as a programmatic and as a factual matter . . . "); *id.* at 35 ("[b]oth as a programmatic matter for Medicare reimbursement determinations and as a factual matter in this case, the Secretary's conclusion that respondent's 'loss' on defeasance relates to more than one accounting period [is allegedly justified]"). In the *Mother Frances* case, the Administrator's decision did not cite to testimony of record to support the secretary's "economic reality" contention. In neither the District Court nor the Court of Appeals did the Secretary undertake to support the findings in the Administrator's decision by making a substantial evidence argument based upon citations to the record.[16]

CONCLUSION

There is no conflict among the circuits or other reason that would make it necessary to grant certiorari in this case.[17] Accordingly, certiorari should be denied in *Mother*

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[16] A few citations to the record appeared in the briefing before the District Court and Court of Appeals, but never as part of a substantial evidence argument advanced by the Secretary.

[17] The advance refunding issue is unlikely to be of "continuing importance," as the Secretary asserts. Guern. Pet. at 25, n.14. Because of the transition to the capital PPS system, Guern. Pet. at 4, n.1, only a small percentage of hospitals or their facilities are being reimbursed on a "reasonable cost" basis after October 1, 1991. These consist principally of psychiatric,

Frances, and the Hospital respectfully suggests that certiorari may have been improvidently granted in *Guernsey* as well.

Should the Court decide *Guernsey* on its merits, the Hospital believes that the following dispositions would be appropriate for the instant case. If the Court finds in favor of Guernsey Memorial Hospital on either of the two questions expressly presented in that case (the GAAP issue or the rulemaking issue) and thus affirms the Sixth Circuit's *Guernsey* decision, the instant case would be governed by such rulings and certiorari should be denied in this case. If the Court finds against Guernsey Memorial Hospital on both issues, certiorari should be granted in the instant case and the case should be remanded to the Fifth Circuit for further consideration in light of *Guernsey*, with leave for the lower courts to consider the substantial evidence issue. Should the Court reach the substantial evidence issue in *Guernsey*, the Hospital also believes that granting certiorari and remanding the *Mother Frances* case would be appropriate due to the fact

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rehabilitation, and long term care facilities. 42 C.F.R. §§ 412.22-412.30. Thus, for general acute care hospitals, losses from advance refundings would rarely be appealed for cost years after 1990. Cost reports must normally be settled within fifteen months after the close of the hospital's fiscal year. *See* 42 C.F.R. § 413.24(f)(2); PRM § 2905.1. Therefore, most of the appeals likely to raise this issue have already been filed, and many of them have been resolved. Instead of bringing certainty to an uncertain area, granting of certiorari and reversal of *Mother Frances* and *Guernsey* would disrupt the unanimous line of decisions on advance refundings and cause determinations in favor of dozens of hospitals to be overturned. *See* Amicus Br. of Hospitals Participating in *St. John Hospital et al. v. Shalala*, 1-4 (28 hospitals in *St. John* appeal alone). Such a result is undesirable when new advance refunding cases are unlikely to arise to any significant extent in the future, most of the cases have either been decided or are well into the process of appeal and judicial review, and the lower courts are unanimous in their treatment of these cases.

that there are different administrative records in the two cases.

Respectfully submitted,

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